| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | | A. BUILDING 00<br>B. WING | 03/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| KINGSTON AT DUPONT | 1716 E DUPONT RD<br>FORT WAYNE, IN 46825 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| R 0000<br><br>Bldg. 00 | This visit was for a State Residential Licensure Survey.<br><br>Survey dates: March 24 and 25, 2025.<br><br>Facility number: 003000<br><br>Residential Census: 29<br><br>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed March 31, 2025 | R 0000 | The Plan of correction is being prepared and executed because it is required by the provisions of state regulation, and not because Kingston at Dupont agrees with the allegations and citations listed on the statement of deficiencies. Kingston at Dupont maintains that alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Kingston at Dupont's written credible allegations of compliance. This plan of correction is not meant to establish any standard of care contract, obligation or position, and Kingston at Dupont reserves all possible contentions and defenses in any civil or criminal actions or proceeding. Please accept the date of correction of 4/23/25, as the facility's credible allegation of compliance. We respectfully request paper compliance for all deficiencies in the following plan of correction. | |
| R 0121<br><br>Bldg. 00 | 410 IAC 16.2-5-1.4(f)(1-4)<br>Personnel - Noncompliance<br><br>Based on record review and interview, the facility | R 0121 | Employee 17 and 18 completed | 04/23/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Dorian Shoemaker | Executive Director | 04/09/2025 |

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | failed to maintain health reports related to annual tuberculosis screening for 2 of 5 employees reviewed (License practical nurse (LPN) 17, and Certified nursing assistant (CNA) 18).<br><br>A record review on 3/24/25 indicated LPN 17, hired on 10/26/2022, did not have documentation of an annual tuberculosis screening completed in 2024.<br><br>A record review on 3/24/25 indicated CNA 18, hired on 6/22/2020 did not have documentation of an annual tuberculosis screening completed in 2024.<br><br>In an interview, on 3/25/25 at 11:05 AM, the Human Resource Director indicated LPN 17 and CNA 18 did not have records for tuberculosis screening annual risk assessment due in 2024.<br><br>A current policy, titled "Tuberculosis, Employee Screening (Indiana)", received on, 3/24/25 at 11:07 AM, from the Human Resource Director, indicated tuberculosis would be screened on the anniversary date of hire for all employees. | | the annual TB symptoms questionnaire. All employee records have been audited for annual TB test compliance. At each employee's annual evaluation we will ensure that each employee completes the TB Symptom Questionnaire to stay in annual compliance. Managers have been educated on the annual TB symptom questionnaire process. The executive director/designee will complete a quality assurance audit to ensure compliance with the annual TB questionnaires, weekly for 4 weeks, bi-weekly for 4 weeks and then monthly for 4 months. Any record out of compliance will be addressed at the time and re-education will be conducted as needed. The audit findings will be reported to the Executive Director/Designee and will be reviewed with managers in department head meetings for 6 months. | |
| R 0356<br><br>Bldg. 00 | 410 IAC 16.2-5-8.1(i)(1-8)<br>Clinical Records - Noncompliance<br><br>Based on interview and record review the facility failed to ensure a hospital preference was available in emergency files for 2 of 5 residents reviewed (Resident 10, and Resident 30).<br><br>Findings include:<br><br>1) Resident 10's record was reviewed on 3/25/25 at 9:32 AM. Diagnoses included Alzheimer's disease, | R 0356 | Resident 10 and 30's clinical record was updated with their hospital preference. All resident clinical records have been audited to ensure hospital preference is present. Upon admission executive director/designee will ensure that each resident's clinical record has their hospital | 04/23/2025 |

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| | depression and osteoporosis.<br><br>A review of the Resident Emergency Files book indicated Resident 10's hospital preference was not included in her emergency file.<br><br>2) Resident 30's record was reviewed on 3/25/25 at 9:34 AM. Diagnoses included other amnesia, tranisient cerebral ischemic attack, and muscle wasting and atrophy.<br><br>A review of the Resident Emergency Files book indicated Resident 30's hospital preference was not included in her emergency file.<br><br>During an interview. on 3/25/25 at 9:44 AM, the Director of Nursing (DON) indicated he was unable to find a hospital preference on the Emergency file forms for Resident 10 and Resident 30. He indicated a hospital preference should be recorded on the emergency file form.<br><br>During an interview, on 3/25/25 at 10:01 AM, the Director of Nursing indicated a policy pertaining to emergency files was not available for review. The DON indicated the regulations require a hospital preference to be present in the resident's emergency file. | | preference present. The executive director/ designee will complete a quality assurance audit to ensure that every resident's clinical record has their hospital preference present, weekly for 4 weeks, bi-weekly for 4 weeks and then monthly for 4 months. Any clinical record out of compliance will be addressed at the time and re-education will be conducted as needed. The audit findings will be reported to the executive director/designee and will be reviewed with managers in department head meetings for 6 months. | |