STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
		155479	B. WING			03/14/2025		
				CTREET	ADDRESS CITY STATE ZID COD			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
KINGSTON CARE CENTER OF FORT WAYNE					/ WASHINGTON CENTER RD			
KINGSTC	ON CARE CENTER	OF FORT WAYNE		FORT	WAYNE, IN 46825			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SECTION		TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
F 0000								
Bldg. 00								
	This visit was for th	e Investigation of Complaint	F 0000		This Plan of Correction is bein	Γhis Plan of Correction is being		
	IN00454446.				prepared and executed because it			
					is required by the provisions of			
	Complaint IN00454	446 - Federal/State deficiencies				state regulation, and not because		
	related to the allegat	tions are cited at F684.			Kingston Care Center of Fort			
	_				Wayne agrees with the allegations			
	Survey dates: March	1 14, 2025			and citations listed on the			
	Facility number: 000522 Provider number: 155479				statement of deficiencies. Kingston Care Center of Fort			
					Wayne maintains that the alleged			
	AIM number: 10026	57040			deficiencies do not individually or			
				collectively jeopardize the health				
	Census Bed Type:				and safety of the residents, no			
	SNF/NF: 70				are they of such character as			
	SNF: 41				limit our capacity to render			
	Total: 111			adequate care as prescribed by		у		
	Census Payor Type: Medicare: 25 Medicaid: 54				regulation. This plan of correction			
					shall operate as Kingston Care Center of Fort Wayne's written			
					credible allegations of compliance.			
	Other: 32				This plan of correction is not			
	Total: 111				meant to establish any standa	rd of		
					care contract, obligation or			
	This deficiency refle	ects State Findings cited in			position, and Kingston Care Center of Fort Wayne reserves all			
	accordance with 410	) IAC 16.2-3.1.						
	Quality reivew completed March 17, 2025				possible contentions and defe	nses		
					in any civil or criminal actions	or		
					proceedings.			
					Please accept the date of			
					correction 03/24/2025, as the			
					facility's credible allegation of			
					compliance. We respectfully			
					request paper compliance.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Alicia Holifield HFA 03/24/2025

Any defiency statement 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: D60F11 Facility ID: 000522 If continuation sheet Page 1 of 6

	MEDICARE & MEDIC				OMB NO. 0938-039	
		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED	
155479		155479	B. WING		03/14/2025	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	2		V WASHINGTON CENTER RD		
KINGSTO	ON CARE CENTER	R OF FORT WAYNE		WAYNE, IN 46825		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
F 0684	483.25					
SS=D	Quality of Care					
Bldg. 00						
	Based on interview	and record review, the facility	F 0684	It is the policy and practice of	03/24/2025	
	failed to ensure a su	argical wound was assessed		Kingston Care Center of Fort		
		of 3 residents reviewed		Wayne to provide residents with	th I	
	(Resident P).			professional standards of pract		
	(-1351331111).			ensuring that residents receive		
	Findings include:			treatment and care in accordar		
	i mamga maraac.			with professional standards of		
	On 3/14/25 at 11:19	5 A M Resident P's record was		practice, the comprehensive		
	On 3/14/25 at 11:15 A.M., Resident P's record was reviewed. Diagnoses included dementia with behavioral disturbance and fracture of the right femur (12/23/24).  A nurse note, dated 12/17/24 at 6:35 p.m., indicated Resident P had a fall and was observed			1 -	۱ ا	
				person-centered care plan, and the residents' choices.	u	
				Due to the resident, identified t		
				have been affected is no longe	er	
				residing in the facility, the		
				corrective action for the deficie	ent	
		n in his doorway. The resident		practice cannot be addressed		
		and holding his right hip. He		within, nor at the time of		
		ergency room for evaluation		identification of the deficient		
	and treatment.			practice.		
	A hospital operative	e report, dated 12/19/25,		Facility corrective actions for a	any	
	indicated the reside	ent had fallen and fractured the		resident(s) that may have		
	top of his right fem	ur. A right hip cemented		potentially been affected include	de	
		eplacing the ball at the top of		record review for any potential		
		h a metal implant and securing		residents with immediate		
		nal Institue of Health) was		correction(s) as applicable.		
		surgical incision closed with		Facility to assure all residents		
	staples.			residing in the facility to receive	e	
	1			aftercare for surgical wounds v		
	An Admission Eval	luation, dated 12/23/24 at 4:00		ongoing assessments and		
		ident P was readmitted to the	1	monitoring. This was complete	d	
	_	spital. He was alert and denied		by the DON on 3/17/2025 and	· · ·	
		ound at the time following		audits began thereafter.		
	_	ractures. Skin observation		audits began thereafter.		
		ent had no skin issues.		Magauraa put into place to		
	maicated the reside	iit nau no skin issues.		Measures put into place to		
	A D1: D1 C	C 4-4-112/22/24: 1 1 1	1	ensure systemic changes and	-11	
		Care, dated 12/23/24 included	1	prevention of re-occurrence in		
the resident would be comfortable, would receive		1	re-education of nursing employ	yees		

If continuation sheet

NAME OF PROVIDER OR SUPPLIER  KINGSTON CARE CENTER OF FORT WAYNE  Ox4, ID SUMMARY STATEMENT OF DEFICIENCIE PREERY (EACH DEPICIENCY MUST BE PRECEDED BY PLLL TAG therapy services, was at risk for falls, had impaired skin integrity due to decreased mobility, and had pain related to osteoarthritis.  The Admission Evaluation with Baseline Plan of Care did not indicate the resident had a surgical wound microsim, closed with staples, or dressings present or not present. There was no description of the surgical incision and no documentation of signs or symptoms of infection.  An admission Minimum Data Set (MDS) assessment, datied 12/28/24, indicated the resident had a surgical wound care (Surgical wound care may include any interventin for treating or present grap and signs and symptoms of infection.  An admission difficulties of surgical wound care (Surgical wound care may include any interventin for treating or presenting my type of surgical or main and present of surgical wound. Examples may include topical cleamsing, wound irrigation, application of a minimicrobial oritiments, application of dressings of any type, surrecispal ermoval, and warm soaks or heat application-Resident Assessment Instrument [RA1] 2024).  A care plan, dated 1/8/15, indicated the resident was at risk for impaired skin integrity related to decreased mobility, impaired circulation, impaired sensition, and incinnence. Interventions included: encourage/assist to turn/reposition; pressure reductions surface to bed; and treatments as ordered.  A Medication Administration Record (TAR), dated December 2024, did not indicate the resident received surgical wound area, surgical wound assessment, monitoring, nor observation for signs and symptoms of infection.  A Medication Administration Record (TAR), dated December 2024, did not indicate the resident received surgical wound area, surgical wound assessment, monitoring, nor observation for signs and symptoms, nonitoring, nor observation for signs and symptoms of infection.  A Medication Administration R	STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
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Ox9   ID   SUMMARY STATEMENT OF DEFICIENCIE   (BACH DEFICIENCY MUST BE PRECEDED BY FULL TAG)   REGULATIONS OF LEST CENTER SERVING SEASON	NAME OF PROVIDER OR SUPPLIER							
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signs or symptoms of infection.  An admission Minimum Data Set (MDS) assessment, dated 12/28/24, indicated the resident had a surgical wound and received surgical wound care (Surgical wound care may include any intervention for treating or protecting any type of surgical wound. Examples may include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application-Resident Assessment Instrument [RAI] 2024).  A care plan, dated 1/8/25, indicated the resident was at risk for impaired skin integrity related to decreased mobility, impaired circulation, impaired sensation, and incontinence. Interventions included: encourage/assist to turn/reposition; pressure reduction surface in wheelchair; pressure redistribution surface to bed; and treatments as ordered.  Will review medical records, admission documentation, and care plan for presence of surgical wound. Surgical wounds will have daily monitoring for healing and signs and symptoms of infection. Addits will be conducted 3 times a week for 8 weeks, then 2 times a week for 8 weeks. Any abnormal findings will be addressed at the time and re-education will be conducted. Any discrepancies will be reported to the QAPI committee and additional education provided as identified on an individual basis. QAPI sommittee or review audits for pattern/trend and continued recommendations for ongoing improvement.  We respectfully request paper compliance.  Date of Completion: 03/24/2025			_			The Director of Nursing /Desi	nnee	
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received surgical wound care, surgical wound assessment, monitoring, nor observation for signs						Date of Completion: 02/24/20	25	
assessment, monitoring, nor observation for signs		· ·				Date of Completion: 03/24/20	20	
		_	_					
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AND PLAN OF CORRECTION   IDENTIFICATION NUMBER   155479	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER  KINGSTON CARE CENTER OF FORT WAYNE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION  A nurse note, dated 12/24/24 at 1:39 p.m., indicated the resident had moderate bleeding to his right hip and the dressing was changed. The note did not indicate notification to the physician had occurred nor further assessment completed of		
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the surgical wound appearance.  There was no further documentation completed on the resident's surgical wound, status of staples, signs or symptoms of infection, bleeding, nor dressings applied from 12/25/24 through 1/6/25.  A nurse note, dated 1/7/25 at 2:51 p.m., indicated a follow up appointment with the orthopedic surgeon was made for 1/22/25 at 2:45 p.m. pending response from the orthopedic (ortho) team regarding staple removal.  Skilled nurse notes, dated 1/9/25 at 1:25 a.m., 1/10/25 at 6:48 p.m., 1/11/25 at 6:57 p.m., 1/12/25 at 7:00 p.m., 1/13/25 at 3:11 p.m., and 1/15/25 at 9:52 a.m. indicated Resident P had no surgical wounds.  A nurse note, dated 1/10/25 at 2:39 p.m., indicated clarification of staple removal had been given by the ortho team. Staples were to remain in and not to be removed at his appointment on 1/22/25.  An electronic MAR (eMAR), dated 1/19/25 at 7:27 p.m., indicated staples were dry and intact without signs or symptoms of infection.  A nurse note, dated 1/22/25 at 4:00 p.m., indicated Resident P had returned to the facility from his orthopedic appointment with new orders for showering and may get incision wet.		

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Event ID:

D60F11

Facility ID: 000522

If continuation sheet Page 4 of 6

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
155479			B. W	ING		03/14/	/2025
NAME OF P	DOMDED OF CURPUSE			STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					WASHINGTON CENTER RD		
KINGSTON CARE CENTER OF FORT WAYNE				FORT V	VAYNE, IN 46825		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX  (EACH CORRECTIVE ACTION SHOULD B)  CROSS-REFERENCED TO THE APPROPE  DEFICIENCY)		TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	A TAR, dated January 2025, indicated an order, dated 1/15/25-1/22/25, was for staff to monitor						
		nts right hip and notify the					
	-						
	physician of signs or symptoms of infection every shift.						
	There was no care r	plan put in place to assess,					
	-	the surgical wound for signs					
		ection. Skilled nurse notes					
		dent P had a surgical wound.					
		urgical wound occurred 1					
	time on 1/19/25 when it had been assessed as dry,						
	intact, and without signs or symptoms of infection.  "Evaluation of Surgical Wounds" was retrieved from woundsource.com on 3/14/25 which						
	indicated: A general physical examination						
	including current pain assessment should be						
	completed and docu	mentation of the wound					
	completed which in	cludes the anatomic location					
	-	rgical incision, the closure					
		ires or staples, bleeding,					
	· ·	ess/swelling) or drainage					
	-	I monitor any sutures,					
	staples, and glue sites and make sure an order is in place for removal-timing of suture or staple removal varies from 3-21 days. Monitoring the						
		event or minimize surgical site					
	-						
	infections. Symptoms of infection may include fatigue, malaise, fever, warmth/redness around the incision, excessive bleeding or foul smelling						
	drainage.						
	On 3/14/25 at 11:59	A.M., Registered Nurse (RN) 2					
		ne indicated upon admission,					
		vas to be assessed including					
	any wounds-surgica						
		progress notes. Resident P's					
	-	uld have been assessed and					
1	g						I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

D60F11

Facility ID: 000522

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/25/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		00	COMPLETED	
		155479	B. WING			03/14/2025	
				STDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					WASHINGTON CENTER RD		
KINGSTON CARE CENTER OF FORT WAYNE					VAYNE, IN 46825		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
	documented upon admission and the wound						
		ored for signs of infection					
	daily.						
	0 2/14/25 + 12.24	DM the Director CN					
		6 P.M., the Director of Nursing					
	, ,	ewed. She indicated Resident					
	P's surgical wound should have been assessed upon admission and every shift until removal of the staples or follow up with the surgeon had occurred. Staff should've observed the surgical incision for signs of non-healing, signs of						
	infection, and obtained a date for staple removal						
	when he returned from the hospital.						
	A current facility policy, titled "Wound and Skin						
	Management Protocol" was provided by the DON						
	_	P.M. The DON indicated the					
	facility had no specific policy regarding surgical						
	wound care and the current policy was used for all resident skin impairments. The protocol indicated:  "An admission assessment/observation should be completed within the first 8 hours but no greater than 24 hoursa plan of care for skin integrity was to be initiated including treatment orders if applicable and appropriate interventions						
	put in place"						
	pat in place						
	This Citation refers	to Complaint IN00454446.					
		-					
	3.1-37						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: D60F11 Facility ID: 000522 If continuation sheet Page 6 of 6