STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155479	A. BUILDING 00 B. WING	03/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
KINGSTON CARE CENTER OF FORT WAYNE	1010 W WASHINGTON CENTER RD FORT WAYNE, IN 46825

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00454446. Complaint IN00454446 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: March 14, 2025 Facility number: 000522 Provider number: 155479 AIM number: 100267040 Census Bed Type: SNF/NF: 70 SNF: 41 Total: 111 Census Payor Type: Medicare: 25 Medicaid: 54 Other: 32 Total: 111 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality reivew completed March 17, 2025	F 0000	This Plan of Correction is being prepared and executed because it is required by the provisions of state regulation, and not because Kingston Care Center of Fort Wayne agrees with the allegations and citations listed on the statement of deficiencies. Kingston Care Center of Fort Wayne maintains that the 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 Care Center of Fort Wayne'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 Care Center of Fort Wayne reserves all possible contentions and defenses 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 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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F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure a surgical wound was assessed and monitored for 1 of 3 residents reviewed (Resident P). Findings include: 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 on the floor of room in his doorway. The resident was yelling in pain and holding his right hip. He was sent to the emergency room for evaluation and treatment. A hospital operative report, dated 12/19/25, indicated the resident had fallen and fractured the top of his right femur. A right hip cemented hemiarthroplasty (replacing the ball at the top of the femur bone with a metal implant and securing with cement-National Institue of Health) was performed and the surgical incision closed with staples. An Admission Evaluation, dated 12/23/24 at 4:00 p.m., indicated Resident P was readmitted to the facility from the hospital. He was alert and denied pain. He was bed bound at the time following surgery related to fractures. Skin observation indicated the resident had no skin issues. A Baseline Plan of Care, dated 12/23/24 included the resident would be comfortable, would receive	F 0684	It is the policy and practice of Kingston Care Center of Fort Wayne to provide residents with professional standards of practice ensuring that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Due to the resident, identified to have been affected is no longer residing in the facility, the corrective action for the deficient practice cannot be addressed within, nor at the time of identification of the deficient practice. Facility corrective actions for any resident(s) that may have potentially been affected include record review for any potential like residents with immediate correction(s) as applicable. Facility to assure all residents residing in the facility to receive aftercare for surgical wounds via ongoing assessments and monitoring. This was completed by the DON on 3/17/2025 and audits began thereafter. Measures put into place to ensure systemic changes and prevention of re-occurrence include re-education of nursing employees	03/24/2025

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	therapy services, was at risk for falls, had impaired skin integrity due to a skin tear on his left lower extremity, was at risk for further 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 incision, 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, 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. A Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated December 2024, did not indicate the resident received surgical wound care, surgical wound assessment, monitoring, nor observation for signs and symptoms of infection.		regarding facility policies with respect to surgical after care monitoring and documentation, SOM PP F684, and PCC re-education r/t documentation. Employees will receive ongoing re-education as applicable along with the auditing process of this plan of correction. The Director of Nursing /Designee 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. Audits will be conducted 3 times a week for 8 weeks, then 2 times a week for 8 weeks then 1 time 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 committee to review audits for pattern/trend and continued recommendations for ongoing improvement. We respectfully request paper compliance. Date of Completion: 03/24/2025	

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	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 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 by staff. The staples would 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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	A TAR, dated January 2025, indicated an order, dated 1/15/25-1/22/25, was for staff to monitor staples to the residents right hip and notify the physician of signs or symptoms of infection every shift. There was no care plan put in place to assess, monitor, or observe the surgical wound for signs or symptoms of infection. Skilled nurse notes didn't indicate Resident P had a surgical wound. Assessment of the surgical 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 documentation of the wound completed which includes the anatomic location and length of the surgical incision, the closure method such as sutures or staples, bleeding, inflammation (redness/swelling) or drainage present. Assess and 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 surgical site can prevent 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 was interviewed. She indicated upon admission, the resident's skin was to be assessed including any wounds-surgical or pressure, and documented in the progress notes. Resident P's surgical wound should have been assessed and			

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	documented upon admission and the wound assessed and monitored for signs of infection daily. On 3/14/25 at 12:36 P.M., the Director of Nursing (DON) was interviewed. 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 on 3/14/25 at 2:03 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 hours...a plan of care for skin integrity was to be initiated including treatment orders if applicable and appropriate interventions put in place...." This Citation refers to Complaint IN00454446. 3.1-37			