STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155479	A. BUILDING -- B. WING	09/05/2024

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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E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/05/24 Facility Number: 000522 Provider Number: 155479 AIM Number: 100267040 At this Emergency Preparedness survey, Kingston Care Center of Fort Wayne was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 137 and had a census of 117 at the time of this survey. Quality Review completed on 09/06/24	E 0000	The statements made in this plan of correction is not an admission to and do not constitute an agreement with the deficiencies alleged herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance such that an alleged deficiency cited has been corrected by the date indicated. **Please accept the date of correction of 09/20/24 as the facility's credible allegation of compliance. We respectfully request paper compliance for all deficiencies in the following plan of correction.**	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000	The statements made in this plan of correction is not an admission to and do not constitute an	

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

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	Survey Date: 09/05/24 Facility Number: 000522 Provider Number: 155479 AIM Number: 100267040 At this Life Safety Code survey, Kingston Care Center of Fort Wayne was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) Chapter 19, Existing Health Care Occupancies and with 410 IAC 16.2. The original one-story facility built in 1981 and the 2013 addition was determined to be of Type V (111) construction and was fully sprinklered. The one-story 2007 addition was determined to be Type II (000) and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detector in resident rooms with exception of rooms 401 through 405 which contained battery operated smoke alarms. The building is fully protected by a Bi-fuel (natural gas and diesel) powered 300 kW emergency generator. The facility has a capacity of 137 and had a census of 117 at the time of this survey. All areas where the residents have customary access were sprinklered. The facility had a detached un-sprinklered storage building providing facility services which was used for the storage of mowing equipment. Quality Review completed on 09/06/24		agreement with the deficiencies alleged herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance such that an alleged deficiency cited has been corrected by the date indicated. **Please accept the date of correction of 09/20/24 as the facility's credible allegation of compliance. We respectfully request paper compliance for all deficiencies in the following plan of correction.**	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 1 of 4 hazardous soiled linen rooms were separated from other spaces by smoke resistant partitions. This deficient practice could affect 50 residents in two smoke compartments. Findings include: Based on observations with the Maintenance Director on 09/05/24 at 10:38 a.m. and 11:10 a.m., in the 100-hall soiled linen room there were nine unsealed screw size holes and in the 500-hall soiled linen room there were two unsealed screw size holes. Based on interview at the time of the observation, the Maintenance Director agreed there were unsealed holes in the two soiled linen rooms. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0321	The facility failed to ensure holes in the walls in fire rated rooms were sealed using fire rated intumescent caulk. This task was completed on 9/5/24, see exhibit 2. This task will be monitored by the regional maintenance manager quarterly during his audits to ensure it is completed, see exhibit 1.	09/20/2024
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code, 2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0345	The facility failed to ensure that the fire alarm panel time was changed in accordance to daylight saving time. This was completed on 9/19/24 using a form sent by ASG, see exhibit 3. The regional maintenance manager will monitor on a quarterly basis during quarterly audits, see exhibit 1.	09/20/2024

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	Based on observation of the fire alarm control panel (FCP) with the Maintenance Director on 09/05/24 at 10:32 p.m., the time on the display of the FCP indicated the time was 09:41 a.m. when checked at 10:32 a.m. Based on interview at the time of observation, the Maintenance Director agreed the FCP had the wrong time. The finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to ensure 7 of 7 sprinkler riser's gauges were replaced every 5 years or documented as tested every 5 years by comparison with a calibrated gauge. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.3.2.1 states gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice could affect 75 residents in the 100, 200, and 300 halls. Findings include: Based on observations with the Maintenance Director on 09/05/24 at 11:36 a.m. and 12:12 p.m., the100-hall sprinkler systems had four pressure gauges dated 2017, and the 200-hall sprinkler systems had three pressure gauges dated 2017. No recalibration date information was affixed to	K 0353	The facility failed to have the fire sprinkler gauges changed on a required rotation as per NFPA 25-9.75-9.77-9.78, this was completed on 9/9/24 by Indiana Fire Sprinkler & Backflow, see exhibit 4. This will be monitored by the regional maintenance manager on a quarterly basis to ensure completion, see exhibit 1.	09/20/2024

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	the sprinkler system gauges. Based on interview at the time of the observations, the Maintenance Director agreed the aforementioned gauges were older than five years and were not recalibrated. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure penetrations through 1 of 8 smoke barrier walls smoke barriers were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. LSC Section 8.5.2.1 requires smoke barriers to be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier, or by use of a combination thereof. 8.5.6.2 requires penetrations for cables, cable trays, conduits, pipes, tubes, vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a smoke barrier, or through the ceiling membrane of the roof/ceiling of a smoke barrier assembly, shall be protected by a system or material capable of restricting the movement of smoke. This deficient practice could affect staff and at least 50 residents in two smoke compartments. Findings include:	K 0372	The facility failed to ensure that the smoke barriers on 8 halls were fire sealed using intermesent caulk, this was completed on 9/20/24, see exhibit 5. This will be audited quarterly by the regional maintenance manager to ensure no other findings, see exhibit 1.	09/20/2024

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	Based on observation with the Maintenance Director and the Facilities Maintenance Supervisor on 09/05/24 at 12:20 p.m., above the drop ceiling of the 300-hall smoke wall there was an inch gap around a conduit. Based on interview at the time of observation, the Maintenance Director agreed there was an unsealed penetration in the 300-hall smoke barrier. The finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			