| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MU | (X2) MULTIPLE CONSTRUCTION (X3) | | | X3) DATE SURVEY | |
|--|----------------------|-----------------------------------|---------------------------------|--------|--|-----------------|------------|
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | A. BU | A. BUILDING | | COMPLETED | | |
| 155479 | | B. WI | B. WING | | | 09/05/2024 | |
| | | | | CTDEET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | WASHINGTON CENTER RD | | |
| KINGSTO | ON CARE CENTER | R OF FORT WAYNE | | | WAYNE, IN 46825 | | |
| MINOOTO | | COLLOCK WATNE | | TORT | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY O | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| E 0000 | | | | | | | |
| | | | | | | | |
| Bldg | | | | | | | |
| | | paredness Survey was | E 00 | 000 | The statements made in this p | lan | |
| | | ndiana Department of Health in | | | of | | |
| | accordance with 42 | 2 CFR 483.73. | | | correction is not an admission | to | |
| | | | | | and do not constitute an | | |
| | Survey Date: 09/0 | 5/24 | | | agreement | | |
| | | | | | with the deficiencies alleged | | |
| | Facility Number: 0 | | | | herein. | | |
| | Provider Number: | | | | To remain in compliance with | | |
| | AIM Number: 100 | 267040 | | | federal and state regulations, | | |
| | | | | | center has taken or will take the | | |
| | | Preparedness survey, | | | actions set forth in the followir | ıg | |
| | | ter of Fort Wayne was found in | | | plan | _ | |
| | | mergency Preparedness | | | of correction. The following pl | | |
| | _ | Medicare and Medicaid | | | correction constitutes the cent | | |
| | | ders and Suppliers, 42 CFR | | | allegation of compliance such | | |
| | · · | y has a capacity of 137 and had a | | | an alleged deficiency cited ha | S | |
| | census of 117 at the | e time of this survey. | | | been | | |
| | | | | | corrected by the date indicate | d. | |
| | Quality Review co | mpleted on 09/06/24 | | | Please accept the date of | | |
| | | | | | correction | | |
| | | | | | of 09/20/24 as the facility's | | |
| | | | | | credible | | |
| | | | | | allegation of compliance. We | ; | |
| | | | | | respectfully | | |
| | | | | | request paper compliance fo | r | |
| | | | | | all | | |
| | | | | | deficiencies in the following | | |
| | | | | | plan | | |
| | | | | | of correction. | | |
| K 0000 | | | | | | | |
| 11.0000 | | | | | | | |
| Bldg. 01 | | | | | | | |
| Diag. 01 | Δ Life Safety Code | e Recertification and State | K 00 | 000 | The statements made in this r | lan | |
| | | was conducted by the Indiana | K 00 | JUU | The statements made in this p | ıalı | |
| | I - | olth in accordance with 42 CFR | | | correction is not an admission | to | |
| | 483.90(a). | in in accordance with 72 Crix | | | and do not constitute an | U | |
| | 100.50(4). | | 1 | | and do not constitute an | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | |
|------------------------------|---|----------------------------------|----------------------------|--------|---|------------------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | a. building <u>01</u> | | 01 | COMPLETED | |
| | | 155479 | B. WING | | | 09/05/2024 | |
| | | | | _ | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | | | | | WASHINGTON CENTER RD | | |
| KINGSTO | ON CARE CENTER | OF FORT WAYNE | | FORT | VAYNE, IN 46825 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | DROVIDED'S DI AN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | TE | COMPLETION |
| TAG | REGULATORY OR LSC IDENTIFYING INFORMATION | | | TAG | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | IE | DATE |
| | | | | | agreement | | |
| | Survey Date: 09/05 | 5/24 | | | with the deficiencies alleged | | |
| | , | | | | herein. | | |
| | Facility Number: 00 | 00522 | | | To remain in compliance with | all | |
| | Provider Number: 1 | | | | federal and state regulations, | | |
| | AIM Number: 1002 | | | | center has taken or will take th | | |
| | | | | | actions set forth in the following | | |
| | At this Life Safety (| Code survey, Kingston Care | | | plan | ·9 | |
| | | ne was found not in | | | of correction. The following pl | an of | |
| | - | equirements for Participation in | | | correction constitutes the cent | | |
| | _ | , 42 CFR Subpart 483.90(a), | | | allegation of compliance such | | |
| | | re and the 2012 edition of the | | | an alleged deficiency cited has | | |
| | | | | | been | _ | |
| | National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) Chapter 19, Existing Health | | | | corrected by the date indicated | d | |
| | Care Occupancies and with 410 IAC 16.2. | | | | Please accept the date of | ۵. | |
| | Care Occupancies and with 410 IAC 10.2. | | | | correction | | |
| | The original one-story facility built in 1981 and the 2013 addition was determined to be of Type V | | | | of 09/20/24 as the facility's | | |
| | | | | | credible | | |
| | | and was fully sprinklered. The | | | allegation of compliance. We | ١ | |
| | | ition was determined to be | | | respectfully | • | |
| | - | vas fully sprinklered. The | | | request paper compliance fo | ır | |
| | | arm system with smoke | | | all | - | |
| | • | ridors, areas open to the | | | deficiencies in the following | | |
| | | wired smoke detector in | | | plan | | |
| | | exception of rooms 401 | | | of correction. | | |
| | | contained battery operated | | | 0.0000 | | |
| | _ | building is fully protected by a | | | | | |
| | | and diesel) powered 300 kW | | | | | |
| | | or. The facility has a capacity | | | | | |
| | | nsus 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 | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | _ | ervices which was used for the | | | | | |
| | storage of mowing | | | | | | |
| | | | | | | | |
| | Quality Review cor | mpleted on 09/06/24 | | | | | |
| | | | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155479 | | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 09/05/2024 | |
|--|---|---|--|--------|---|---------------------------------------|----------------------|
| | PROVIDER OR SUPPLIE | R R OF FORT WAYNE | | 1010 W | ADDRESS, CITY, STATE, ZIP COD V WASHINGTON CENTER RD 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 |
| K 0321 SS=E Bldg. 01 | failed to ensure 1 o | on and interview, the facility | K 0 | 321 | The facility failed to ensure ho in the walls in fire rated rooms | | 09/20/2024 |
| | rooms were separated from other spaces by smoke resistant partitions. This deficient practice could affect 50 residents in two smoke compartments. Findings include: | | | | 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 | | |
| | Director on 09/05/2 the 100-hall soiled unsealed screw siz soiled linen room t size holes. Based of observation, the M | ons with the Maintenance 24 at 10:38 a.m. and 11:10 a.m., in linen room there were nine e holes and in the 500-hall here were two unsealed screw on interview at the time of the aintenance Director agreed d holes in the two soiled linen | | | ensure it is completed, see ex | hibit | |
| | _ | viewed with the Administrator Director during the exit | | | | | |
| K 0345 SS=C Bldg. 01 | NFPA 101 Fire Alarm System - Testing and | | K 0. | 345 | The facility failed to ensure the the fire alarm panel time was changed in accordance to day saving time. This was comple on 9/19/24 using a form sent I ASG, see exhibit 3. The regio maintenance manager will more on a quarterly basis during quarterly audits, see exhibit 1. | ylight ted by nal onitor | 09/20/2024 |
| | | | | | <u>-</u> | | 1 |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155479 | | (X2) MULTIPLE CO A. BUILDING B. WING | <u></u> | | | |
|---|--|---|---------------------|--|------------------------|--|
| | PROVIDER OR SUPPLIER | | 1010 V | ADDRESS, CITY, STATE, ZIP COD V WASHINGTON CENTER RD WAYNE, IN 46825 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | |
| K 0353 SS=E Bldg. 01 | panel (FCP) with the 09/05/24 at 10:32 pthe FCP indicated the checked at 10:32 and time of observations agreed the FCP had. The finding was revelous Director and Admir conference. 3.1-19(b) NFPA 101 Sprinkler System - Based on observation failed to ensure 7 of replaced every 5 years by congauge. NFPA 25, Stresting, and Mainted Protection Systems, states gauges shall be tested every 5 years calibrated gauge. Opercent of the full sereplaced. This deficit residents in the 100. Findings include: Based on observation birector on 09/05/2 the 100-hall sprinkle gauges dated 2017, systems had three p | - Maintenance and Testing on and interview, the facility 7 sprinkler riser's gauges were ars or documented as tested imparison with a calibrated standard for the Inspection, onance of Water-Based Fire 2011 Edition, Section 5.3.2.1 be replaced every 5 years or by comparison with a dauges not accurate to within 3 cale shall be recalibrated or cient practice could affect 75 | K 0353 | The facility failed to have the f 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 Indian Fire Sprinkler & Backflow, see exhibit 4. This will be monitore the regional maintenance man on a quarterly basis to ensure completion, see exhibit 1. | a a d by ager | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155479 | | (X2) MULTIPLE CO A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 09/05/2024 | | |
|--|---|---|---------------------------------------|--|----------------------|
| | ROVIDER OR SUPPLIER | OF FORT WAYNE | 1010 V | ADDRESS, CITY, STATE, ZIP COD V WASHINGTON CENTER RD WAYNE, IN 46825 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| K 0372 SS=E Bldg. 01 | at the time of the ob- Director agreed the older than five years The finding was rev and Maintenance D conference. 3.1-19(b) NFPA 101 Subdivision of Bui Barrie Based on observation failed to ensure pen smoke barrier walls to maintain the smo barrier. LSC Section barriers to be constr Section 8.5 and shall resistive rating. LSC smoke barriers to be wall to an outside we from a smoke barrier of a combination the penetrations for cab pipes, tubes, vents, accommodate electr and communication wall, floor, or floor/ as a smoke barrier, membrane of the ro assembly, shall be p material capable of | agauges. Based on interview observations, the Maintenance aforementioned gauges were is and were not recalibrated. Triewed with the Administrator irector during the exit Iding Spaces - Smoke In and interview, the facility etrations through 1 of 8 Is smoke barriers were protected ke resistance of each smoke in 19.3.7.5 requires smoke fucted in accordance with LSC in have a minimum ½ hour fire it is section 8.5.2.1 requires it is econtinuous from an outside fall, from a floor to a floor, or it is a smoke barrier, or by use ereof. 8.5.6.2 requires les, cable trays, conduits, wires, and similar items to rical, mechanical, plumbing, is systems that pass through a feeling assembly constructed for through the ceiling of/ceiling of a smoke barrier protected by a system or restricting the movement of tent practice could affect staff ents in two smoke | K 0372 | The facility failed to ensure the the smoke barriers on 8 halls fire sealed using intermesent caulk, this was completed on 9/20/24, see exhibit 5. This waudited quarterly by the regio maintenance manager to ensure to other findings, see exhibit | were ill be nal ure |

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

PRINTED: 03/21/2025 FORM APPROVED OMB NO. 0938-039

| | | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155479 | ì ′ | JILDING | INSTRUCTION 01 | (X3) DATE COMPL 09/05/ | ETED |
|---|--|---|-----|---------------------|---|------------------------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER KINGSTON CARE CENTER OF FORT WAYNE | | | | 1010 W | ADDRESS, CITY, STATE, ZIP COD WASHINGTON CENTER RD VAYNE, 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 COMP | | (X5) COMPLETION DATE |
| | 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) | | | | | | |

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