STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			ì í	E SURVEY	
		155479				MPLETED 15/2025	
100473							
NAME OF P	ROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP COD WASHINGTON CENTER RD		
KINGSTON CARE CENTER OF FORT WAYNE				WAYNE, IN 46825			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF COR		ection (X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
Ŭ	This visit was for the Investigation of Complaints		F 00	00	This Plan of Correction is being		
	IN00456678, IN004	458140 and IN00458555.			prepared and executed because it is required by the provisions of state regulation, and not because Kingston Care Center of Fort		
	Complaint IN00456	6678 - No deficiencies related to					
	the allegations are o	eited.					
				Wayne agrees with the allegatio		tions	
	Complaint IN00458140 - Federal/State deficiencies				and citations listed on the		
	related to the allegations are cited at F585.				statement of deficiencies.		
	G 1: Digatests N 1 C 1				Kingston Care Center of Fort		
	Complaint IN00458555 - No deficiencies related to			Wayne maintains that the alleged			
	the allegations are cited.				deficiencies do not individually		
	Survey dates: May 14 and 15, 2025				collectively jeopardize the hea and safety of the residents, no		
	Survey dates: May 14 and 13, 2023				are they of such character as		
	Facility number: 000522				limit our capacity to render	10	
	Provider number: 155479				adequate care as prescribed by	ov	
	AIM number: 100267040				regulation. This plan of correc	-	
					shall operate as Kingston Car		
	Census Bed Type:				Center of Fort Wayne's writter		
	SNF/NF: 71			credible allegations of compliance.			
	SNF: 32				This plan of correction is not		
	Total: 103				meant to establish any standa	rd of	
					care contract, obligation or		
	Census Payor Type:				position, and Kingston Care		
	Medicare: 13			Center of Fort Wayne reserves all possible contentions and defenses			
	Medicaid: 70						
	Other: 20				in any civil or criminal actions or		
	Total: 103				proceeding. Please accept the date of		
	This deficiency reflects State Findings cited in			correction 05/30/2025, as the			
	accordance with 410 IAC 16.2-3.1.			facility's credible allegation of			
	accordance with 410 IAC 10.2-3.1.			compliance. ¿ We respectfully			
	Quality review completed May 16, 2025			request paper compliance.¿			
	· •	•			, , ,		
					="" p="">		
					="" p="">		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) I						(X6) DATE	

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

(X6) DATE

Alicia Holifield **HFA** 06/05/2025

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: OBOX11 Facility ID: 000522 If continuation sheet Page 1 of 5

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
		155479	B. WING			05/15/2025		
				STREET ADDRESS, CITY, STATE, ZIP COD				
NAME OF PROVIDER OR SUPPLIER					/ WASHINGTON CENTER RD			
KINGSTON CARE CENTER OF FORT WAYNE					WAYNE, IN 46825			
MINGST	ON CARE CENTER	OF FORT WATNE		FORT				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG				TAG			DATE	
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					="" p="">			
					="" p="">			
					="" p="">			
					="" p="">			
E 0505								
F 0585	483.10(j)(1)-(4)							
SS=D	Grievances							
Bldg. 00							0.5/0.0/	
		on, interview and record	F 0:	585	It is the policy and practice of		05/30/2025	
		failed to ensure grievances	ļ		Kingston Care Center of Fort			
	were thoroughly investigated, contained required documentation, and appropriate corrective actions taken for 1 of 3 residents reviewed with grievances (Resident Q). Findings include:				Wayne for residents residing i	n		
					the facility to be able to voice grievances without discrimination			
				or reprisal.				
					Resident Q no longer resides at			
					the facility at the time of review	W .		
	A report dated 4/23	3/25, alleged Resident Q was			All residents residing in have	the		
	rushed and handled roughly during personal care provided by Certified Nurse Aide (CNA) 2.				potential to be by deficient	_		
					practice. The facility conducte	h-d		
					audits of meeting notes for mo			
	On 5/14/25 at 12:55	P.M., Resident Q's record was			of April of May to concerns. N			
	reviewed. Diagnoses included hemiplegia				adverse outcomes noted defic			
	_	iparesis (weakness) following			practice.			
	a stroke affecting th				'			
					Measures put into place to en	sure		
	A nurse note, dated 4/6/25 at 1:26 p.m., indicated Resident Q had arrived to the facility from the hospital. She was alert, oriented and able to make				systemic changes included			
					re-education of facility policies	3		
					with to the grievance process			
	her needs known to	staff. She'd had a recent			location of grievance concern			
	stroke with express	ive aphasia (difficulty speaking			forms. Employees will receive			
		sis on the right side. She			ongoing education and will be			
		ne pain on her "entire right			to demonstrate understanding			
		assistance of 1 with			policy elements.			
	completing her activ	vities of daily living (ADL).						
	-				Social service director, or , wil	II		
	A respiratory therap	by note, dated 4/10/25 at 9:55			audit by record review, and			
	a.m., indicated Resi	dent Q was to receive			grievance documentation of			
assistance with using her incentive spirometer but				resident concerns requiring				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155479 B. WING STREET ADDRESS, CITY, STATE, ZIP COD 1010 W WASHINGTON CENTER RD FORT WAYNE, IN 46825 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION had refused due to being upset about how the CNA had gotten her up. A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 1010 W WASHINGTON CENTER RD FORT WAYNE, IN 46825 (X5) CMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION A TURNO TO BE A MADE OF THE APPROPRIATE DEFICIENCY DATE A TURNO TO BE A MADE OF THE APPROPRIATE DEFICIENCY DATE A TURNO TO BE A MADE OF THE APPROPRIATE DESIGNATION A TURNO TO BE A MADE OF THE APPROPRIATE DESIGNATION DATE A TURN
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 RAG REGULATORY OR LSC IDENTIFYING INFORMATION had refused due to being upset about how the CNA had gotten her up. STREET ADDRESS, CITY, STATE, ZIP COD 1010 W WASHINGTON CENTER RD FORT WAYNE, IN 46825 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE grievance follow up. This audit will be 3 times weekly for 8 weeks, then twice weekly for 8 weeks,
KINGSTON CARE CENTER OF FORT WAYNE (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION had refused due to being upset about how the CNA had gotten her up. 1010 W WASHINGTON CENTER RD FORT WAYNE, IN 46825 (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE grievance follow up. This audit will be 3 times weekly for 8 weeks, then twice weekly for 8 weeks,
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PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION had refused due to being upset about how the CNA had gotten her up. (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX PREFIX PREFIX PREFIX GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE grievance follow up. This audit will be 3 times weekly for 8 weeks, then twice weekly for 8 weeks,
had refused due to being upset about how the CNA had gotten her up. CNA had gotten her up. TAG BEFICIENCY Grievance follow up. This audit will be 3 times weekly for 8 weeks, then twice weekly for 8 weeks,
had refused due to being upset about how the CNA had gotten her up. CNA had gotten her up. TAG BEFICIENCY Grievance follow up. This audit will be 3 times weekly for 8 weeks, then twice weekly for 8 weeks,
CNA had gotten her up. be 3 times weekly for 8 weeks, then twice weekly for 8 weeks,
then twice weekly for 8 weeks,
A nurse note, dated 4/10/25 at 11:12 a.m., then weekly for 2 months. Any
indicated Resident Q's daughter had gone to the discrepancies will be reported to
nurses station to speak with the nurse about the the QAPI and additional education
morning care her mother had received from CNA The pure immediately want to the resident's provided as identified on an individual basis. (OADI committee)
2. The nurse immediately went to the resident's individual basis.¿QAPI committee
bedside to check on her where no bruising or audits for /trend and continue
other concerns were observed. Management was recommendations for ongoing improvement.
notified. improvement.
There was no follow up documentation in the
medical record after Resident Q's daughter had
expressed care concerns on 4/10/25 through the We respectfully request paper
resident's discharge from the facility on 4/23/25. compliance.
On 5/14/25 at 1:30 P.M., the Social Services
Director (SSD) was interviewed. She indicated the
facility hadn't used grievance forms and when a
concern was brought to a staff members attention, ="" p="">
staff were to address the issue at the time. When
asked, the SSD was unsure of how the facility was
tracking grievances or concerns to ensure prompt ="" p="">
efforts were being made to resolve the grievance, ="" p="">
prevent further potential violations, and ensure
appropriate corrective actions were taken while
the grievance/concern was being reviewed. The
SSD indicated she had no concerns or grievances ="" p="">
reported to her for the month of April or May.
="" p="">
On 5/15/25 at 3:15 P.M., the Administrator was
interviewed and a current copy of the facility ="" p="">
policy for grievances provided. The Administrator indicated the SSD was the facility's designated ="" p=""> ="" p="">
, , ,
Grievance Officer who was responsible for
overseeing the grievance process, receiving and ="" p=""> tracking grievances through to conclusion and ="" p="">
tracking grievances through to conclusion and leading any necessary investigations by the ="" p=""> ="" p="">
facility. The Administrator indicated the facility

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			COMPLETED		
155479		B. WING 05/15/2025					
			STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIER	t.		W WASHINGTON CENTER RD			
KINGSTON CARE CENTER OF FORT WAYNE			FORT WAYNE, IN 46825				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIATE			
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE		
	~	ns, located outside the door of					
		ts, staff, families or visitors to					
	use to convey griev	ances.					
	On 5/15/25 at 3·20	P.M., the Director of Nursing					
		ewed regarding care concerns					
		rted on 4/10/25. She indicated					
		formal grievance had been					
		the Unit Manager followed up					
		d her daughter on 4/11/25. The					
		ed CNA 2 had rushed her and					
		paralyzed side while providing					
	*	dicated she hadn't been hurt					
		e DON indicated she didn't					
	know why there had	-					
		ne resident's record to indicate					
	the grievance had been addressed promptly or actions taken to prevent further violation of the resident's rights while the grievance/concern was investigated.						
	mvestigatea.						
	During an observati	ion on 5-14-25 through 5-15-25,					
	no grievance or con	cern forms were readily					
		n area, nurse's stations or at					
	the SSD office.						
	A current copy of the facility policy, titled						
	"Grievance Policy/Grievance Officer", was provided by the Administrator on 5/15/25 at 3:15 P.M., and stated: "[Facility] ensures the right of residents, and the resident representative to voice and have prompt resolutions to their						
		ns a formal policy when the					
		GO) is approachedThe					
		s responsible for overseeing					
		ss, receiving and tracking					
	grievances through	to their conclusion; leading					
	any necessary inves						
	facilityOther concerns are addressed via the						
	concern form and if	there is not resolution the					
			<u> </u>	<u> </u>			

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Event ID:

OBOX11 Facility ID: 000522

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

PRINTED: 06/10/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155479		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/15/2025			
NAME OF PROVIDER OR SUPPLIER KINGSTON CARE CENTER OF FORT WAYNE			STREET ADDRESS, CITY, STATE, ZIP COD 1010 W WASHINGTON CENTER RD 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	
	concern will be brought to the GO by the resident or resident representative3. If there is a grievance that needs to be given to the GO, the GO will lead the investigation. This will be tracked on the tracking log. 4. The Grievance Officer will follow up with the person who brought forward the concern in approximately 72 hours following review of the concernAfter the investigation the GO will issue final decision to the resident and/or representative" This Citation relates to Complaint IN00458140. 3.1-7(a)(2)							

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