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	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingston Care Center of Fort Wayne	1010 W Washington Center Rd Fort Wayne, IN 46825

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure an exit door remained secure for 1 of 5 residents reviewed (Resident 98). Findings include: Resident 98's record was reviewed on [DATE] at 10:19 AM. Diagnoses included Alzheimer's disease with early onset, restlessness and agitation, and psychotic disorder with delusions due to known physiological condition. A review of Resident 98's current admission Minimum Data Set Assessment (MDS), dated [DATE], indicated their Basic Interview for Mental Status (BIMS) score was 10 (cognitively impaired). The MDS indicated Resident 98 had displayed verbal behavioral symptoms toward others 1-3 days per week and puts others at risk of significant risk of physical injury. The MDS indicated Resident 98 wandered with a significant risk of getting into potentially dangerous places. A review of Resident 98's current care plan titled Risk for Elopement indicated the resident had a problem of being independently ambulatory, having dementia, exit seeking behaviors, and poor safety awareness with a goal date of [DATE]. Interventions included using a wanderguard and checking the wanderguard's function. An elopement assessment, dated [DATE] at 1:48 PM, indicated Resident 98 was fully ambulatory, wandered aimlessly with redirectable behavior, and was content with placement. The assessment indicated Resident 98 had not made any attempts to leave the facility. A review of physician orders dated [DATE] at 2:09 PM, indicated a wanderguard was ordered to be placed on Resident 98's left ankle and staff should check placement and function each shift. A physician's order, dated [DATE] at 7:50 PM, indicated Resident 98 could reside in the facility's locked memory care unit. A review of progress notes, dated [DATE] at 7:00 PM, indicated Assistant Director of Nursing (ADON) 3 was notified by phone Resident 98 exited the building using a side exit and was promptly escorted back into the building. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Progress notes, dated [DATE], did not include an account of Resident 98 exiting the facility, any immediate intervention or physical assessment. Progress notes, dated [DATE] at 7:20 PM, indicated Resident 98 had moved to the memory care unit due to increased wandering and family request. No assessments were included in the progress note. An elopement assessment, signed by the Director of Nursing (DON) on [DATE] with an effective date of [DATE] at 7:00 PM, indicated Resident 98 was fully ambulatory, wandered aimlessly, voiced desire to leave, was difficult to redirect and made at least one attempt to leave the facility. In an interview, on [DATE] at 11:17 AM, ADON 3 indicated he was on call when he received notice of Resident 98 exiting the building. He indicated Resident 98 was originally admitted to a room that was not located on the secured memory care unit. On the day of his admission, Resident 98 was observed to exit the facility through the service hall doorway by a dietary employee who was placing trash in the dumpster located about 50 feet from the service hall doorway. The dumpster was in an outdoor area open to the parking lot near the rehabilitation entrance to the facility. He indicated the door was not armed with wanderguard locking devices, but had alarms in place that should have sounded when the door was pushed open. He indicated the staff did not hear the alarm go off. He demonstrated opening the door with no sounding of the alarm. He indicated the alarm should have sounded and did not know why it had been disarmed. He placed a key in the lock on the push bar on the door, turned it, and pushed on the door. The door alarmed loudly when pushed and released after 15 seconds. He indicated each unit nurse had a key to the door to activate the lock clearly marked. He indicated he did not know who had disarmed the door or for what purpose. He indicated the door should be armed when not in direct attendance by staff. In an interview, on [DATE] at 1:19 PM, Maintenance Assistant 6 indicated he checked the service hall exit door earlier on [DATE]. The door had been armed, alarmed and locked properly. He indicated he was not aware of who disarmed the door or for what purpose. He indicated the door alarm should have sounded, and the door should have been locked when pushed. In an interview, on [DATE] at 1:28 PM, the Administrator indicated the door had not locked when pushed because the door became armed after a one-minute delay after the door closed. In an interview, on [DATE] at 1:30 PM, The ADON indicated he had not been aware of the one-minute delay on the service exit door. During a record review, on [DATE] at 1:30 PM, in-service documents provided by the Administrator on [DATE] at 9:00 AM indicated 17 staff members signed in-service sign-in forms beginning [DATE], conducted by the DON pertaining to the topic of the elopement policy. In-service sign-in forms indicated 60 staff members signed in for in-services provided by the Administrator, beginning [DATE] on secured door systems, discussion and demonstration. An employee listing provided by the Administrator on [DATE] at 9:00 AM indicated 199 employees worked at the facility. In an interview, on [DATE] at 1:41 PM, the Director of Nursing (DON) indicated she had presented in-services to staff after the elopement event and covered the information in the elopement policy. She indicated the Administrator performed additional in-servicing including a demonstration of the secured door system. She indicated the facility utilized agency staff to supplement facility staffing to ensure staffing needs were met. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation, on [DATE] at 1:51 PM, the DON entered the door code and opened the service hallway door to the outside of the building. About 10-15 seconds later, she pushed the door, and it opened without delay. The door alarm sounded upon opening. The DON indicated she was not aware of any delay in the locking mechanism engaging after the door closed. During an observation, on [DATE] at 1:58 PM, the Administrator entered the door code and opened the service hallway door to the outside of the building. After allowing the door to close, she waited until a red light appeared on the push bar of the door and pushed on the door again. The door remained locked, and the alarm sounded. She indicated she had performed this demonstration during her in-service to show staff how to ensure the door was armed. She indicated staff were instructed to push on the door after closing it to ensure the alarm sounded. During an interview, on [DATE] at 6:02 AM, Certified Nurse Aide (CNA) 2 indicated the code pad on the wall next to the door armed the door. She indicated when the door was closed it was armed and should alarm when open. She indicated she was not aware of any delay between when the door closed and when it would arm. During an observation, on [DATE] at 6:03 AM, CNA 2 entered a code into the keypad and opened the service hallway door to the outside of the building. She pushed on the door about 15 seconds after it closed. The alarm sounded and the door opened immediately. She indicated she did not know why the locking mechanism did not engage when the door closed. In an interview, on [DATE] at 12:14 PM, the Administrator indicated the exit door used by Resident 98 to exit the facility was about 349 feet from the road. The road was a 4-lane main city thorofare. A document titled Chexit, manufacturers guidelines for use of a controlled egress device was provided by the Administrator on [DATE] at 8:01 AM. The document indicated the Chexit device should sound an alarm and keep the door secured for 15 seconds following an exit attempt with immediate release upon fire. The guideline indicated a rearm delay was the amount of time after the key switch was activated before the alarm sounded. The guideline indicated the rearm time could be changed from 2 seconds to 28 seconds in 2 second increments. The document indicated if the rearm time was set to 30 seconds and a door position switch (DPS) was used, the door would not alarm after the rearm time expired. The Chexit would not rearm until the door was closed. If not using a DPS, the Chexit would rearm in 30 seconds. If the DPS detected the door closed during a rearm delay, the Chexit ended the rearm delay and allowed 2 seconds for the latch to clear the strike before rearming. A current policy, dated 11/23 provided by the Administrator on [DATE] at 1:31 PM, indicated the facility staff should immediately assist the resident in returning to the building and document the event in the medical record. This citation is related to complaint IN00459756. 3.1-45(a)(2)