STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	07/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARBOR GLEN INDEPENDENT & ASSISTED LIVING COMMUNIT	5202 ST JOE ROAD FORT WAYNE, IN 46835

(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
R 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00411184 and IN00411781. Complaint IN00411184 - No deficiencies related to the allegations are cited. Complaint IN00411781 - State deficiencies related to the allegations are cited at R0147. Survey date: July 10 and 11, 2023 Facility number: 015503 Residential Census: 74 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed July 13, 2023	R 0000		
R 0147 Bldg. 00	410 IAC 16.2-5-1.5(d) Sanitation and Safety Standards - Deficiency (d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities. Based on interview and record review, the facility failed to ensure fire prevention interventions were initiated for 114 of 114 residents resided in the building. Findings include: On 7/11/23 at 10:40 A.M., Resident F's record was reviewed. Diagnoses included end stage chronic obstructive pulmonary disease, nicotine	R 0147	Arbor Glen Independent & Assisted Living Survey 7/11/2023 Plan of Correction The following Plan of Correction is prepared and submitted by Arbor Glen Independent & Assisted Living Community, Fort Wayne as mandated by the Indiana State Department of Health. However,	07/27/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Kathryn Bolling	Administrator/ED	07/24/2023

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	dependence, and sleep disorder with excessive sleepiness. A Service Plan, dated 3/16/23, indicated the resident required assistance with showers, medications, and setting up transportation. On 7/11/23, the service plan was updated to indicate the resident used tobacco and required assistance for storing her cigarettes and lighter. Staff were to store and hand them out when the resident was on her way outside to smoke. A physician order, dated 3/16/23, was for oxygen at 2.5 liters, as needed, to keep oxygen saturation >91%. A Smoking-Safety Screen, dated 6/16/23 at 10:43 a.m., indicated the resident had no cognitive loss. She was capable of transferring, traveling to designated smoking areas 20 feet away from the building and was capable of lighting her own cigarettes. The resident posed a threat to herself and other residents in the building by smoking on her balcony while using oxygen and falling asleep with a lit cigarette. The resident had been educated and provided the protocol of facility smoking guidelines per lease. She hadn't abided by these terms and had been re-educated with protocols and documentation on 4/9/23. Physician progress notes indicated the following: -3/21/23 at 1:35 p.m., the resident was visited in her room. She had been wearing nasal oxygen and her apartment smelled strongly of cigarette smoke. She indicated she went outside to smoke and the facility had warned her about the danger. -5/16/23 at 11:13 a.m., the resident was visited on this day. She was frail and had her oxygen on.		this response does not constitute agreement with the allegations or citations specified on the Statement of Deficiencies. Arbor Glen Independent & Assisted Living Community, 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 applicable regulations. Our process has been amended adding more safeguards in reference to people who smoke cigarettes. We respectfully request a paper compliance for the following citations. **R 147** 410 IAC 16.2-5-1.5(d) Sanitation and Safety Standards - Deficiency (d) The facility shall comply with fire and safety standards, including the applicable rules of the state fire prevention and building safety commission (675 IAC) where applicable to health facilities. This RULE is not met as evidenced by: R 147 Based on interview and record review the facility failed to ensure residents smoked in designated smoking areas within 20 feet of the building. 114 residents reside in the building. Resident record noted the Resident (F) posed a threat to herself & others in the building by smoking on her	

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	-6/13/23 at 12:14 p.m., the resident was seen for a routine visit. Her physical exam indicated her lung sounds were diminished and she wore her oxygen via nasal cannula. She continued to report daytime sleepiness. Event notes were as follows: -3/17/23 at 10:49 a.m., the resident was observed walking in the hall with her rolling walker and complained of difficulty breathing. She was assisted back to her room. Upon entrance to her room, cigarette smoke was smelled. When asked, the resident indicated she had smoked in her room and indicated she wouldn't do it again. She was reminded smoking wasn't allowed in the building, or her room where she had oxygen which was dangerous. -5/29/23 at 1:24 p.m., the resident was observed smoking on her balcony at lunch time. She was reminded not to smoke on the balcony. -6/2/23 at 11:43 a.m., the resident was observed smoking on her balcony. -At 7:30 p.m., Resident F was observed on the floor in her apartment. She reported that she had blacked out. The resident was on strong narcotics for pain. -6/10/23 at 1:38 p.m., the resident was observed smoking on the balcony this shift. She was reminded smoking was not allowed in the building or patios. -6/14/23 at 11:29 a.m., the resident was observed in her nightgown and no shoes sitting on her balcony smoking.		balcony while using oxygen & falling asleep with a lit cigarette. Resident had been educated and provided the protocol of facility guidelines for smoking. She failed to abide by these guidelines and had been re-educated with protocols & documentation on 4/9/2023. Even though this Resident was educated numerous times, this Resident continued to violate the guidelines and her cigarettes & lighter were taken to nursing station. When she wants them she has to go to nursing station to get them, is assisted outside, where she is supervised by an employee, then return lighter when she is done smoking outside. **1.What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident was smoking on her balcony, Administrator reviewed with this Resident and All Residents the no smoking policy as well as additional discussion about not smoking in the building which includes patio/balcony. Showed this resident as well as all Residents where the smoking areas are. She & all Residents voiced understanding of this. **2.How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	

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	-6/15/23 at 10:54 a.m., the resident was smoking on her balcony. She was educated about facility protocol and guidelines on smoking. -6/16/23 at 11:29 a.m., the resident was observed to be asleep, with her oxygen on, smoking on her balcony. She was educated again and provided with the smoking policy per lease. A smoking assessment was completed and she was no longer safe to smoke unsupervised. Nursing was to hold and dispense her cigarettes to her and transport her to the designated smoking area. 14 packs of unopened cigarettes, 1 opened pack with 4 cigarettes remaining, and 2 lighters were removed from the residents apartment. -6/26/23 at 5:45 p.m., the resident was observed smoking in her bathroom where cigarette butts lay in the toilet. She was wearing her oxygen via nasal cannula. She was educated on the current smoking policy and safety concerns with smoking in her apartment while oxygen was being used. The resident indicated she understood and this was the first time she had smoked in her room since nursing management had intervened with supervised smoking. She gave staff a pack of cigarettes and lighter and indicated she had no more in her possession. -7/2/23 at 6:18 p.m., the resident had been given 2 cigarettes to take outside to smoke. She was brought back into the building by another resident because she couldn't stay awake outside to smoke. The residents oxygen level was 78% (normal >90%). She was taken back to her room and her oxygen placed back on. -7/3/23 at 9:02 a.m., Over the last several days, Resident F had an increase in confusion, anxiety and pain. She had been found smoking on her		**taken:** All Residents have received additional reminders, review of no smoking policy in person explaining no smoking in the building, including patios/balconies as well as where all of the smoking areas are. Reminded where smoking areas are at, added an additional smoking area that is covered - protects Residents from rain, snow, etc. **3.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** 1. The facility team was educated on the significant issue and our responsibility to oversee the community to ensure compliance. Inservice training was on or before 7/27/2023. This inservice has been on all monthly staff training agenda's for months. All employees were trained that if they see someone not following this policy they are to address the resident immediately and guide them to the smoking area. Also, to let leadership know and Administrator will meet with the Resident immediately. 2. There are 5 smoking areas with one covered (Gazebo) around the building, all at least 20 ft from building. **4.How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	balcony and most recently, had been found smoking in her bathroom while wearing her oxygen. She had been educated to not smoke in her apartment or on the balcony. She was treated for pain and anxiety. The resident was not alert on this morning, and complained of pain. "It is believed she had begun transitioning" to active dying. Her pain and anxiety medications were increased and changed from pill form to liquid. -7/11/23 at 1:59 a.m., the resident was up in her wheelchair and had gone outside to smoke. During confidential employee interviews, staff indicated residents were to only smoke outside in designated areas and were prohibited from smoking in their rooms, balconies, or patios. If observed, staff would explain to the resident that they had to put out the cigarette immediately and would report this to the supervisor. Staff indicated Resident F had been reported to management several times due to observations of smoking in her room and balcony while wearing oxygen which was dangerous for her and everyone else who lived and worked in the building. There were 114 res=idents residing in the building. Staff indicated there were no set smoking times with staff present to provide supervision although occasionally, staff that smoked would sit out with the resident's smoking while on their break. Staff indicated residents that used oxygen were to have a sign on the door indicating oxygen was in use however, Resident F's room door had no sign to indicate the resident used oxygen. On 7/11/23 at 1:07 P.M., the Administrator and Director of Nursing (DON) were interviewed. The Administrator indicated the resident had been re-educated several times about smoking in her room but had not issued a 30 day discharge		**recur, i.e., what quality assurance program will be put into place: -** The Administrator and all any/staff will be walking the interior & exterior of the building monitoring Residents who are known to be smokers as well as any others. This is to ensure compliance with the Smoke Free Community policy & State Regulation. This will occur at least three times daily for the first 2 months; Then A minimum of twice daily for 2 months; Then 1 time daily for 2 months. If a Resident is found to be smoking inside building/apartment/balcony or patio, they are told that they will be reported and will need to meet with the Administrator. Administrator meets with them immediately - Discussion will be that due to their violation, they will need to leave all of their cigarettes & lighters at the front desk and can get them when they need them but, could no longer have them in apartment due to the violation. IF it occurs again, the next step is eviction. The policy was amended adding these steps. The Administrator &/or Designee will evaluate the audits and develop an action plan after the 6 months if necessary. **1.Compliance date: 7/27/2023**	

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	because the resident had started on hospice services and was declining. The DON indicated there should have been documentation of the use of oxygen which had been a physician order for the resident. She indicated the resident hadn't required staff supervision while smoking but had required staff to keep her cigarettes and lighter to be given to her when she wanted to go outside to smoke in an attempt to prevent her from smoking on her room/balcony. The Administrator indicated this intervention hadn't been successful because the resident was able to get cigarettes and lighter from someone or somewhere. When questioned, she indicated residents who use oxygen were to have signs on the door to indicate oxygen was in use. Resident F previously had a sign on her door and she would get another one up right away. A current policy, titled "Smoking Prohibited", was provided by the Administrator on 7/11/23 at 1:59 P.M. and stated the following: "It is the intent of the Community to allow those residents who wish to smoke, the opportunity to do so in a an environment with optimal safety to themselves other residents, visitors and staff members...Resident shall not smoke while using or around oxygen. If Community staff determines that Resident's unsupervised smoking presents a fire or burn risk, Resident will not be allowed to smoke without appropriate supervision. The Community may provide this service to Resident for an additional change...Resident agrees not to smoke when drowsy. Resident agrees not to smoke when drinking alcohol or taking medications which may cause drowsiness...If Resident violates this smoking policy or any other smoking rules and regulations of the Community, whether communicated to Resident verbally or in writing, it may be grounds for eviction."			

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	This State Residential finding relates to Complaint IN00411781.			