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	11/08/2023

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 IN00419785 and IN00420387. Complaint IN00419785 - State deficiencies related to the allegations are cited at R0064 and R0090. Complaint IN00420387 - No deficiencies related to the allegations are cited. Survey date: November 6 and 8, 2023 Facility number: 015503 Residential Census: 73 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality reivew completed November 9, 2023	R 0000		
R 0064 Bldg. 00	410 IAC 16.2-5-1.2(hh) Residents' Rights- Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on interview and record review, the facility failed to ensure a resident's property was protected from loss and theft for 1 of 3 residents reviewed (Resident B). Findings include: A complaint, submitted to the Indiana Department	R 0064	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, this response does not constitute agreement with the allegations or	11/17/2023

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

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	of Health (IDOH), dated 10/16/23, alleged Resident B was missing 9 Lyrica (for nerve pain) capsules which had been unaccounted for. On 11/6/23 at 2:28 P.M., QMA 3 (Qualified Medication Aid) was interviewed. She indicated the morning of 9/30/23, she counted the resident's Lyrica capsules, prior to starting her shift, as required by regulations for controlled substances. She indicated there were 161 capsules in the bottle but there should've been 170 capsules according to the Controlled Drug Use Record. She immediately notified the Director of Nursing (DON) via text message of the missing capsules. The DON texted her back she would look into the concern. On 11/8/23 at 10:11 A.M., Resident B's record was reviewed. Diagnoses included polyneuropathy. A physician's order, dated 11/7/22, was for Lyrica capsules 300 milligrams-give 1 capsule by mouth 2 times per day. A Controlled Drug Use Record indicated the facility had received 170 Lyrica capsules from the pharmacy on an unknown date/time. An entry, by the Director of Nursing (DON), on 10/4/23, indicated there were 9 capsules of Lyrica which were unaccounted for and there were only 161 capsules in the bottle. An internal Investigation Summary, provided by the DON on 11/8/29 at 10:49 A.M., indicated an investigation of the missing medication was started on 10/4/23. The facility was unable to find a reason or cause for 9 Lyrica capsules to be missing. On 11/8/23 at 2:30 P.M., the Administrator and		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. We respectfully request a paper compliance for the following citations. In relation to Complaint IN00419785 **R 064** 410 IAC 16.2-5-1.2(hh) Residents' Rights[1]Noncompliance (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. This RULE is not met as evidenced by: R 064 Based on interview and record review, the facility failed to ensure a resident's property was protected from loss and theft for 1 of 3 residents reviewed (Resident B). 1 **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	

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	DON were interviewed. Both indicated they were unable to determine what happened to the missing Lyrica capsules despite their investigation. The Administrator indicated Resident B, her physician, and pharmacy were notified of the missing medication. Staff who worked on the cart where the medication was missing were re-educated on counting controlled medications. This citation relates to Complaint IN00419785.		**practice:** Resident B had 9 missing pills from her Lyrica Medication in the Medication Cart, Administrator, DON & ADON investigated this thoroughly and did not find why these pills were gone. We had a strong suspicion of 1 particular employee, but no proof. (That employee is no longer with us at Arbor Glen.) All employees involved in this occurrence of; 1. Not counting the med every shift & 2. Were signing that the counts were correct; were re-trained on counting meds every shift and given a corrective action. This occurrence could have been found quicker had they been counting. This Resident didn't miss any doses of her medication. Resident, her family/POA & MD were notified, and the Community did replace the medication.2 **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All Nursing team have received additional training on counting of controlled medications at each shift. DON & ADON are doing cart shift change observations to ensure this.**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 Nursing team (Nurses & QMA's)	

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			were re- educated on the significant issue and responsibility to complete medication counts to ensure compliance. Shift change cart medication counts take 2 employees. (Oncoming employee and employee leaving.) Inservice training was on or before 11/17/2023. All employees were trained that if they see someone not following this policy they are to address them immediately and notify the DON. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: -**DON & ADON are doing cart shift change observations ensuring that all are following Community policy & State Regulation. This will occur at least once daily for the first 2 months; Then A minimum of three times per week for 2 months; then for an additional 2 months at least 2 times per week. The Administrator &/or DON will evaluate the audits and develop an action plan if necessary.**Compliance date: 11/17/2023**	
R 0090 Bldg. 00	410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following:			

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	(1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability. (6) Maintaining reports of surveys conducted			

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	by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on interview and record review, the facility failed to report to the Indiana Department of Health misappropriation of residents property for 1 of 3 residents reviewed. (Resident B). Findings include: A complaint submitted to the Indiana Department of Health (IDOH), dated 10/16/23, alleged Resident B was missing 9 Lyrica (for nerve pain) capsules which had been unaccounted for. On 11/8/23 at 10:11 A.M., Resident B's record was reviewed. Diagnoses included polyneuropathy. A physician's order, dated 11/7/22, was for Lyrica capsules 300 milligrams-give 1 capsule by mouth 2 times per day. A Controlled Drug Use Record indicated the facility had received 170 Lyrica capsules from the pharmacy on an unknown date/time. An entry, by the Director of Nursing (DON), on 10/4/23, indicated there were 9 capsules of Lyrica which were unaccounted for. Only 161 capsules were left in the bottle. On 11/8/23 at 2:30 P.M., the Administrator was interviewed. She indicated she had not reported the missing medication to the Indiana Department of Health as required by regulations. A current facility policy, titled "Reporting Unusual Occurrences", was provided on 11/8/23 at 11:02 A.M. by the DON and stated the following: "...this community will ensure that all	R 0090	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, 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. We respectfully request a paper compliance for the following citations. In relation to Complaint IN00419785 **R 090** 410 IAC 16.2-5-1.3(g)(1-6) Administration and Management - Deficiency (g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence	11/24/2023

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	unusual occurrences that directly threaten the welfare, safety, or health of a resident will be reported to IDOH and other appropriate authorities within twenty-four hours of becoming aware of the occurrence...Unusual occurrences must be reported by every team including but not limited to...Misappropriation of resident property is the deliberate misplacement, exploitation or wrongful, temporary or permanent use of resident's property or money, regardless of the value, without the resident's consent. This does also include medications...." This citation relates to Complaint IN00419785.		that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to th (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a	

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			notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request emergency telephone number published by the division. This RULE is not met as evidenced by: Based on interview and record review, the facility failed to report to the Indiana Department of Health misappropriation of residents' property for 1 of 3 residents reviewed. (Resident B). **1. What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B had missing property/misappropriation of property that was not reported to the Indiana Department of Health. This was missed in error after thorough investigation was completed, notifications were made to Resident, Residents POA, Residents MD & Residents Pharmacy and facility replaced the missing/misappropriated property. The Resident was not harmed by this and the community replaced the property. Administrator, DON & ADON will be collaborating with one another to maintain compliance in reporting incidents. **2 How will you identify other residents having the potential**	

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			to be affected by the same deficient practice and what corrective action will be taken: Administrator, DON & ADON will be collaborating in efforts to maintain compliance in reporting of any occurrences outlined in R090. Administrator, DON and ADON will reach out to Our Regional Director or State area supervisor if any questions arise of concern or if in need of any guidance. **3 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** Administrator, DON & ADON reviewed & signed the Regulation and Policies on our responsibility to report all items in R090 to ensure compliance. We completed Inservice training on or before 11/17/2023. Systemically, we have added Incident reporting reviews to our Daily Directors Meeting Form so that this is reviewed every day - ongoing. **4 How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: -**Administrator, DON & ADON will ensure compliance with the State Regulation & Policy. It has been added to our Policy that the Administrator, DON & ADON will review any/all	

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			incidents daily to ensure that they are being reported per the Regulation and Policy. This will be daily at end of the Directors Meeting & as needed. This system will be Daily & Ongoing (with no end date) and was added to our Daily Directors Meeting Form. Formally, the Audit form will be used for 3 months then document only on the Directors Meeting Form after the 3 months. The Administrator, DON & ADON will evaluate the audits and develop an action plan if necessary. (Copy of Audit form and copy of Directors Meeting Form attached). This process has been added to our policy. (attached) Compliance date: 11/24/2023	