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	04/17/2023

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 Complaint IN00406093 and IN00406351. Complaint IN00406093 - State deficiencies related to the allegation is cited at R0147. Complaint IN00406351 - No deficiencies related to the allegations are cited. Survey date: April 17. 2023. Facility number: 015503 Residential Census: 105 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed April 18, 2023	R 0000	No Deficiencies notes.	
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 residents smoked in designated smoking areas within 20 feet of the building. This action resulted in a fire. 105 residents resided in the building. (Resident B). Findings include: A facility reported incident, dated 4/9/23, was provided by the Administrator on 4/17/23 at 2 PM.	R 0147	**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	04/27/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mary Kathryn Bolling	Administrator	04/24/2023

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.

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	The report indicated on 4/9/23, "Chef 3 was outside and observed Resident B smoking on her patio. Shortly after, staff reported an odor of melting plastic. Chef 3 went out the back kitchen door and observed black smoke coming from Resident B's patio. Chef 3 had gotten large buckets of water and notified the front desk staff to bring a fire extinguisher. The staff contacted the local fire department who arrived at the facility after the fire was out. The investigation concluded the fire was caused by a cigarette that had not been put out all the way and had rolled under the siding of the building. The investigation also indicated the cigarette had melted/burned the siding." An investigation summary dated 4/9/23, was provided by the Administrator on 4/17/23 at 2 PM. The summary indicated Resident B admitted to smoking on her patio and had thought her cigarette was out. Resident B also indicated the end of the cigarette must have fallen out and rolled under the siding as the fire department indicated. A smoking assessment, dated 3/5/2023, was provided by the Director of Nursing (DON) on 4/17/23 at 3:24 PM. The assessment indicated Resident B was safe to smoke without supervision. The assessment also indicated Resident B understood the risks, potential injuries from smoking and was aware of the designated smoking areas. In an interview on 4/17/23 at 3:18 PM, Chef 3 indicated on 4/9/23 he had walked outside at 3:58 PM and observed Resident B smoking on her patio. Chef 3 indicated a bit later he had noticed a fog like appearance outside the kitchen door. Chef 3 indicated he walked outside and saw flames on		Based on interview and record review the facility failed to ensure residents smoked in designated smoking areas within 20 feet of the building. This action resulted in a fire. 105 residents resided in the building. (Resident B). 1. **What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**: Resident B was smoking on her patio, 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 at, one is about 20 feet from Resident B's patio. 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 taken:** All Residents have received additional guidance, review of no smoking policy in person & given written training, explaining no smoking in the building, including patios/balconies as well as where all of the smoking areas are. Showed where smoking areas are at. 3. **What measures will be put**	

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	Resident B's patio. Chef 3 indicated he immediately pulled the fire alarm, notified the front desk to bring a fire extinguished and grabbed large buckets of water. Chef 3 indicated another staff member called the fire department. Chef 3 also indicated he had checked to see if Resident B was in her apartment but she was not. Chef 3 indicated the fire department had arrived after he had gotten the fire out. Chef 3 indicated residents should not be smoking on their patios and the facility had multiple designated smoking areas around the facility. A policy, dated October 2021, titled "Smoking Free Policy" was provided by the Administrator on 4/17/23 at 2 PM. The policy indicated "smoking is strictly prohibited in the community and outside the community property expected in designated areas." This State citation relates to Complaint IN00406093.		**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 responsibility to oversee the community to ensure compliance. Inservice training was on or before 4/27/2023. 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. 2. We added 3 additional smoking areas 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 recur, i.e., what quality assurance program will be put into place: -** 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 twice daily for the first 2 months; A minimum of once daily for 2 months; The Administrator &/or Designee will evaluate the audits and develop an action plan if necessary. 6. **Compliance date:** 4/27/2023	

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