

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/31/2024
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NAME OF PROVIDER OR SUPPLIER ARBOR GLEN INDEPENDENT & ASSISTED LIVING COMMUNIT	STREET ADDRESS, CITY, STATE, ZIP COD 5202 ST JOE ROAD FORT WAYNE, IN 46835
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R 0000 Bldg. 00	<p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: January 30, and 31, 2024</p> <p>Facility number: 015503</p> <p>Residential Census: 68</p> <p>These State Residential Findings are cited in accordance with 410 IAC 16.2-5.</p> <p>Quality review completed February 1, 2024.</p>	R 0000	<p>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. 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 0151, R 0273 & R 0298. We are requesting an IDR for R 0298.</p>	
R 0151 Bldg. 00	<p>410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance</p> <p>Based on interview and record review, the facility failed to ensure 2 of 16 pets living with residents in the facility had their required immunizations.</p> <p>Findings include:</p>	R 0151	<p>The following Plan of Correction is prepared and submitted by Arbor Glen Independent & Assisted Living Community, Fort Wayne as mandated by the Indiana State</p>	02/09/2024

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>During a record review on 1/31/24 at 10:45 AM, a Pet Binder provided by the Director of Nursing on 1/31/24 at 9:10 AM was reviewed. The Director of Nursing (DON) indicated the binder contained veterinary visit and vaccination records for each pet residing in the facility.</p> <p>A veterinary record, dated 10/27/21, for the cat belonging to Resident 9 indicated the cat received vaccinations including feline distemper and a rabies booster. The record indicated the feline distemper and rabies booster were due to be administered again by 10/27/22. No additional records for Resident 9's cat were available for review.</p> <p>A veterinary record, printed on 4/12/23, with no date, for the cat belonging to Resident 10 indicated the cat received booster vaccines for FVCPRN-FeLV (a combination vaccine including feline distemper) and rabies on 6/30/22. The record indicated these vaccines were due to be re-administered by 6/30/23. No additional records for Resident 10's cat were available for review.</p> <p>During an interview, on 1/31/24 at 11:50 AM, the Business Director indicated vaccinations for all pets in the facility were required to be current. She indicated no further vaccine records were available for review</p> <p>A review of the current facility policy, Permitting & Maintaining Pets, dated October 1, 2021, provided by the DON on 1/31/24 at 9:10AM, indicated, "...All pets brought on the Community's premises must be registered and the registration must be updated annually. Cats must be vaccinated in accordance with the appropriate State and local laws. This includes, but is not</p>		<p>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.</p> <p>R 0151 410 IAC 16.2-5-1.5(h) Sanitation & Safety Standards -Noncompliance (h) Any pet housed in a facility shall have periodic veterinary examinations and required immunizations. This RULE is not met as evidenced by: R 151 Based on interview and record review, the facility failed to ensure 2 of 16 pets living with residents in the facility had their required immunizations.</p> <p>What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: There were missing records for 2/16 Residents. The above referenced pets found without updated vaccinations were called immediately & given a</p>	

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	limited to, feline enteritis and rabies, with booster shots as needed...."		<p>letter to provide records or remove pet from the community. Also provided education to the resident/family as to the state specific regulation until such a time they could arrange for the pet to receive updated vaccinations by an appropriately licensed individual. Pet #1 received vaccinations on 2/1/2024 & Pet #2 received vaccinations on 2/8/2024. Ie. Families or Residents are to provide documentation of updated pet vaccination records and this to be placed within the resident's administrative file prior to the pets return to the community.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:The Business office Director, Executive Director and/or Designee has (and will continue to) review current administrative files pertaining to outdated pet vaccinations. No other residents were found to be affected.What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not reoccur: The Business office Director and/or Designee has created a spreadsheet of Residents with Pets & date of vaccinations.</p>	

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			<p>Also created a 60 day letter that will be given when the due date of vaccinations is approaching. There will then be a 30 day letter that will be given if we haven't received any updated vaccinations. This letter then says that the Resident cannot have the pet on our property unless it is vaccinated. We will then be calling this Resident to get appointment date and follow up until we receive the records. Pet Records will be reviewed with a 1 time per month audit form of the resident's administrative file to ensure pets present in our community as well as entering the community have up to date vaccinations for a period of twelve months through the communities QA process. 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: -The monthly audits will be reviewed after six months in order to determine the need for the ongoing frequency of the monitoring plan. Findings suggestive of compliance will result in cessation of the monitoring plan. These actions are to ensure continued compliance with Indiana state regulation R 151. Compliance</p>	

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R 0273 Bldg. 00	<p>410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency</p> <p>Based on observation, interview, and record review the facility failed to ensure kitchen cleanliness was maintained. 68 of 68 residents residing in the facility consumed meals prepared in the kitchen.</p> <p>Findings include:</p> <p>During a tour of the kitchen with Cook 3 (dietary manager in training and in charge of the kitchen) on 1/30/24 at 9:10 AM a deep fryer was observed with numerous light brown particles floating on top of the grease. The grease in the deep fryer was dark brown in color. The floor under the deep fryer was covered with a thick layer of yellow film. A stack of steam table pans was observed to have water droplets on the top pan and the sides of the pans. Cook 3 separated 4 stacks of steam table pans, all steam table pans were observed to have water between the pans.</p> <p>In an interview on 1/30/24 at 9:15 AM, Cook 3 indicated they were not aware of how often the deep fryer grease was to be cleaned. Cook 3 indicated they were not aware of how often the deep fryer grease was to be changed. Cook 3 indicated the floor under the deep fryer was cleaned every 2 weeks. Cook 3 indicated the kitchen did not have a cleaning schedule. Cook 3 indicated the previous dietary manager had left the facility 1 month ago. Cook 3 indicated the previous dietary manager had not left cleaning schedules behind. Cook 3 indicated the facility was not aware the steam table pans were required</p>	R 0273	<p>Date: 2/9/2024</p> <p>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.</p> <p>R 0273 410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents' units) are being 410 IAC 7-24. This RULE is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure kitchen cleanliness was maintained. 68 of 68 residents</p>	02/09/2024
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	<p>to air dry prior to stacking the pans for storage.</p> <p>In an interview on 1/30/24 at 9:34 AM the Executive Director (ED) indicated the previous dietary manager had been terminated about 1 month ago. The ED indicated the previous DM had destroyed the cleaning schedules and cleaning logs. The ED indicated the steam table pans should be allowed to air dry prior to storage. The ED indicated a cleaning log should be posted and followed.</p> <p>A current policy dated 10/1/21 provided by the ED on 1/30/24 at 1:53 PM indicated all kitchen equipment and surfaces shall be cleaned and sanitized. The policy indicated documentation of cleaning was to be maintained.</p> <p>A master cleaning schedule with no date provided by the ED on 1/30/24 at 1:53 PM. The schedule indicated the oil fryer was to be cleaned daily. The master cleaning schedule indicated the kitchen floors were to be cleaned daily.</p>		<p>residing in the facility consumed meals prepared in the kitchen. Findings include: During a tour of the kitchen with Cook 3 (dietary manager in training and in charge of the kitchen) on 1/30/24 at 9:10 AM a deep fryer was observed with numerous light brown particles floating on top of the grease. The grease in the deep fryer was dark brown in color. The floor under the deep fryer was covered with a thick layer of yellow film. A stack of steam table pans was observed to have water droplets on the top pan and the sides of the pans.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; All Cooks and Dietary Aids have been trained (1/31/2024) on proper cleaning procedures in the kitchen & dining room. Specifically the Fryer cleaning procedures and schedule as well as pans that need to be air dried before stacking.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Residents could be effected by this – the potential for bacteria to be on the pans if they get stacked with moisture still on them and also the Fryer not being cleaned could cause foods to taste bad.</p>	

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			<p>What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; Administrator/ED trained with 2 Dietary Managers, Cooks and Kitchen aids with the new cleaning schedules and checklists that need to be followed DAILY. Both Dietary Managers are walking the kitchen at end of their shifts & checking the cleaning checklist DAILY. Administrator/ED is also checking 3 times a week, that this is being done.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur? Both Dietary Managers are walking the kitchen at end of their shifts & checking the cleaning checklist daily, ongoing (no stop date). Administrator/ED is also checking the kitchen for cleanliness (Specifically, Fryer and that pans have completely dried before being stacked) 3 times a week for 2 months, 2 times per week for 2 months then 1 time per week for 2 months. After the 6 months, Administrator/ED will assess and plans to continue this Audit at least 1 time per week with no end date.</p> <p>By what date the systemic changes will be completed. 2/9/2024</p>	

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

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