

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/18/2025	
NAME OF PROVIDER OR SUPPLIER ARBOR GLEN INDEPENDENT & ASSISTED LIVING COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 5202 ST JOE ROAD, FORT WAYNE, , 46835					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...			(X5) COMPLETION DATE	
R 0000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00452494 and IN00453044. Complaint IN00452494 - State deficiencies related to the allegations are cited at R0214 and R0216. Complaint IN00453044 - No deficiencies related to the allegations are cited. Survey date: February 18, 2025 Facility number: 015503 Residential Census: 82 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed February 19, 2025	R 0000					
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a)	R 0214	Arbor Glen Independent & Assisted Living 015503			03/03/2025	

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(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident.

Based on interview and record review, the facility failed to ensure evaluation of resident ability to self-administer medications was completed semi-annually for 2 of 3 residents reviewed (Resident B and Resident D).

Findings include:

1. On 2/18/25 at 11:16 A.M., Resident B's record was reviewed. Diagnoses included diabetes, lymphedema, and chronic, recurring leg wounds.

A Service Plan for medication management, dated 3/20/24, indicated Resident B was independent with medication management. He was independent with self-administration of medications, was able to obtain new prescriptions, refills, and coordinate with lab appointments. He was on a medication with a possibility of bleeding/bruising and care staff were to report any changes.

A Medication

Complaint Survey 2/18/2025
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, 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.

IN00452494 - State deficiencies related to the allegations are cited at R0214 and R0216.

R214 410 IAC 16.2-5-2(a)
Evaluation - Deficiency (a) An

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Self-Administration Safety Screen form, dated 6/13/24 at 10:44 a.m., indicated a list of all medications being considered for resident self-administration was to be listed on the form including name of medication, route, dose, frequency, and where the medication was to be stored. Resident B's form did not list any medications and a note indicated to "see resident med list". The evaluation indicated the resident was able to correctly identify each medication, state reason for use, time/frequency of medication, and dosage/quantity of medications to be taken. He was able to demonstrate secure storage of medication and indicated appropriate situations for self-administration of as needed (PRN) medications. The evaluation indicated it was not applicable for the resident to correctly administer subcutaneous injections. The evaluation indicated the resident displayed cognitive ability to store and self-administer medications safely. A physician order, dated 6/13/24, indicated the resident could self-administer medications unsupervised.

There were no other assessments available for review.

2. On 2/18/25 at 12:49 P.M.,

evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. This RULE is not met as evidenced by: R 214 Based on interview and record review, the facility failed to ensure evaluation of resident ability to self-administer medications was completed semi-annually for 2 of 3 residents reviewed (Resident B and Resident D).

What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:

1 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:By following the regulation & doing our Audits, we are ensuring that all Residents' Assessments have all been completed timely in

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	Resident D's record was reviewed. Diagnoses included diabetes and congestive heart failure. A Service Plan for medication management, dated 2/24/24, indicated the resident was independent with self-administration of medications but required assistance with administration of insulin, insulin pens and blood sugar checks.		order to ensure care plans are accurate for care. 2 What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur: 1. An Assessment Checklist, will be followed, ensuring that all assessments are completed timely. (2) Care plans are updated appropriately. (3) Resident is aware of changes if any and NP/MD/family/POA notified. (4) Documentation completed. 2. DON, Administrator or Designee will be auditing, to ensure that these items are completed. . 3 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 or designee will be completing an Audit, Bi- Monthly to ensure regulatory compliance, for 3 months; 1 Time per Month for 2 months; Then continue 1 time per month ongoing. The Administrator, DON &/or Designee will evaluate the audits and develop an action plan if	
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A Medication Self-Administration Safety Screen form, dated 2/24/24, indicated a list of oral medications which were stored at the residents bedside. The form indicated insulin (given subcutaneously), vitamin B12 injections (given intramuscularly), and Ozempic (given subcutaneously) were stored with staff but hadn't indicated if staff or the resident administered the injections. The evaluation indicated the resident was able to correctly identify each medication, state reason for use, time/frequency of medication, and dosage/quantity of medications to be taken. The evaluation indicated it was not applicable for the resident to correctly administer subcutaneous injections. A physician order, dated 2/24/24, indicated the resident could self-administer medications unsupervised.

There were no other assessments available for review

On 2/18/25 at 1:14 P.M., the Administrator and Director of Nursing (DON) were interviewed. Both indicated self-administration of medication evaluations should be in resident electronic medical records and there were no paper copies. The DON indicated evaluation of

necessary.

4**Compliance****date: 3/3/2025**

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resident's ability to self-administer medications was to be completed semi-annually prior to Service Plan reviews and as needed if a resident had a change in condition. A former nurse had been tasked to complete the evaluations. When questioned, the DON indicated Resident B should have been evaluated for ability to self-administer medication in December 2024 but the evaluation had not been completed. She indicated Resident D's evaluation to self-administer medications should've been completed in August of 2024 but had not been done.

A current facility policy, titled "Self Administration", was provided by the DON on 2/18/25 at 1:45 P.M., which stated: "An alert and self-sufficient resident may request that his or her physician provide a written order to the facility indicating an ability to self-administer medications. The physician must indicate the resident is capable of taking unsupervised...The nurse at the facility must evaluate each resident who self-administers his or her medication by completing the 'Self-Administration of Medication Assessment' form...Periodic evaluations of the resident's ability to self-administer medications must be made to ensure the

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safe and effective procedures are followed every day...."

This Citation relates to Complaint IN00452494.

Based on interview and record review, the facility failed to ensure evaluation of resident ability to self-administer medications was completed semi-annually for 2 of 3 residents reviewed (Resident B and Resident D).

Findings include:

1. On 2/18/25 at 11:16 A.M., Resident B's record was reviewed. Diagnoses included diabetes, lymphedema, and chronic, recurring leg wounds.

A Service Plan for medication management, dated 3/20/24, indicated Resident B was independent with medication management. He was independent with self-administration of medications, was able to obtain new prescriptions, refills, and coordinate with lab appointments. He was on a medication with a possibility of bleeding/bruising and care staff were to report any changes.

A Medication Self-Administration Safety Screen form, dated 6/13/24 at 10:44 a.m., indicated a list of all medications being considered for resident self-administration

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was to be listed on the form including name of medication, route, dose, frequency, and where the medication was to be stored. Resident B's form did not list any medications and a note indicated to "see resident med list". The evaluation indicated the resident was able to correctly identify each medication, state reason for use, time/frequency of medication, and dosage/quantity of medications to be taken. He was able to demonstrate secure storage of medication and indicated appropriate situations for self-administration of as needed (PRN) medications. The evaluation indicated it was not applicable for the resident to correctly administer subcutaneous injections. The evaluation indicated the resident displayed cognitive ability to store and self-administer medications safely. A physician order, dated 6/13/24, indicated the resident could self-administer medications unsupervised.

There were no other assessments available for review.

2. On 2/18/25 at 12:49 P.M., Resident D's record was reviewed. Diagnoses included diabetes and congestive heart failure.

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A Service Plan for medication management, dated 2/24/24, indicated the resident was independent with self-administration of medications but required assistance with administration of insulin, insulin pens and blood sugar checks.

A Medication Self-Administration Safety Screen form, dated 2/24/24, indicated a list of oral medications which were stored at the residents bedside. The form indicated insulin (given subcutaneously), vitamin B12 injections (given intramuscularly), and Ozempic (given subcutaneously) were stored with staff but hadn't indicated if staff or the resident administered the injections. The evaluation indicated the resident was able to correctly identify each medication, state reason for use, time/frequency of medication, and dosage/quantity of medications to be taken. The evaluation indicated it was not applicable for the resident to correctly administer subcutaneous injections. A physician order, dated 2/24/24, indicated the resident could self-administer medications unsupervised.

There were no other assessments available for review

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	On 2/18/25 at 1:14 P.M., the Administrator and Director of Nursing (DON) were interviewed. Both indicated self-administration of medication evaluations should be in resident electronic medical records and there were no paper copies. The DON indicated evaluation of resident's ability to self-administer medications was to be completed semi-annually prior to Service Plan reviews and as needed if a resident had a change in condition. A former nurse had been tasked to complete the evaluations. When questioned, the DON indicated Resident B should have been evaluated for ability to self-administer medication in December 2024 but the evaluation had not been completed. She indicated Resident D's evaluation to self-administer medications should've been completed in August of 2024 but had not been done. A current facility policy, titled "Self Administration", was provided by the DON on 2/18/25 at 1:45 P.M., which stated: "An alert and self-sufficient resident may request that his or her physician provide a written order to the facility indicating an ability to self-administer medications. The physician must indicate the resident is capable of taking unsupervised...The nurse at the			
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facility must evaluate each resident who self-administers his or her medication by completing the 'Self-Administration of Medication Assessment' form...Periodic evaluations of the resident's ability to self-administer medications must be made to ensure the safe and effective procedures are followed every day...."

This Citation relates to Complaint IN00452494.

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R 0216	Evaluation - Noncompliance 410 IAC 16.2-5-2(c)(1-4)(d) (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on interview and record review, the facility failed to ensure a service plan for diabetes management was developed and implemented for 1 of 3 residents reviewed (Resident B). Findings include: 1. On 2/18/25 at 11:16 A.M., Resident B's record was reviewed. Diagnoses included diabetes, chronic obstructive pulmonary disease, and chronic, recurring leg wounds.	R 0216	R216 410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. This RULE is not met as evidenced by: Based on interview and record review, the facility failed to ensure a service plan for diabetes management was developed and implemented for 1 of 3 residents reviewed (Resident B) What Corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: 1 How will you	03/03/2025
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A Service Plan for medication management, dated 3/20/24, indicated Resident B was independent with medication management. He was independent with self-administration of medications, was able to obtain new prescriptions, refills, and coordinate with lab appointments. He was on a medication with a possibility to cause bleeding/bruising and care staff were to report any changes.

A Medication Self-Administration Safety Screen form, last completed on 6/13/24 at 10:44 a.m., indicated the resident was able to correctly identify each of his medications, state reason for use, time/frequency of medication, dosage/quantity of medications to be taken and demonstrated secure storage of his medications. The evaluation indicated it was not applicable for the resident to correctly administer subcutaneous injections.

A physician progress note, dated 1/23/25 at 11:39 a.m., indicated Resident B was visited to follow up on acute and chronic issues with resultant hospitalizations the past month. The resident was diabetic and obese. During the visit, a discussion was had with the resident about diabetic

identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:
By following the regulation & doing our Audits, we are ensuring that all Residents' Assessments have all been completed timely in order to ensure care plans are accurate for care.

2
What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:

1. A Care Plan/Service Plan review is a part of the Assessment Checklist, will be followed, ensuring that all assessments are completed timely.
(2) Care plans are updated appropriately. (3) Resident is aware of changes if any and NP/MD/family/POA notified. (4) Documentation completed.

2. DON, Administrator or Designee will be auditing, to ensure that these items are completed.

3
How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality

medications to promote weight loss. The weight loss could help with his breathing but the resident was not interested. The resident was currently on insulin.

An Event Note, dated 1/27/25 at 4:04 p.m. and documented by Licensed Practical Nurse 2 (LPN), indicated Resident B reported his blood sugar was high at 479. The nurse texted the Nurse Practitioner (NP) and a new order was given to give 12 units of short acting insulin (Humalog). LPN 2 went to the resident's apartment to tell him of the new order and he informed her he had already taken 20 units of fast acting insulin (Fiasp). LPN 2 texted the NP and reported the resident had medicated himself and staff would monitor him.

The Service Plan hadn't indicated Resident B was prescribed insulin to manage diabetes.

A review of physician orders didn't indicate Resident B was prescribed insulin to manage his diabetes

The most recent completed self-administration of medication evaluation, dated 6/13/24, didn't indicate Resident B was prescribed insulin and his ability to safely administer the medication himself without

assurance program will be put into place: -

Administrator, DON or designee will be competing an Audit, Bi- Monthly to ensure regulatory compliance, for 3 months; 1 Time per Month for 2 months; Then continue 1 time per month ongoing. The Administrator, DON &/or Designee will evaluate the audits and develop an action plan if necessary.

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date: 3/3/2025

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supervision.

A Medication Administration Record (MAR), dated January 2025, indicated the resident had self-administered oral medications as ordered during the month and staff had provided ointments/creams to open areas on his legs. The MAR didn't indicate the resident was prescribed insulin or blood sugar monitoring.

On 2/18/25 at 1:14 P.M., the Administrator and Director of Nursing (DON) were interviewed. Both indicated they hadn't been made aware the resident was prescribed and taking insulin nor how long he had been taking the medication. They were unable to find orders for insulin and indicated if he had been prescribed insulin, a self-administration of medication evaluation would have needed to be completed and changes made to his service plan, if appropriate, prior to the resident self-administering the medication. When questioned, the DON indicated it would be important for staff to be aware he was taking insulin due to the effects of insulin lowering the blood sugar and an assessment completed to indicate the resident could safely administer the medication which was given subcutaneously.

A current facility policy, titled

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"Coordination/Individualization of Service Plan", was provided by the DON on 2/18/25 at 1:45 P.M., and stated: "The community utilizes and individualized, comprehensive service plan for each resident that includes measurable objectives important in meeting the needs of the resident that are based on the resident's preferences and priorities. The service plan is a communication tool that provides associates education related to each resident's needs and preferences and assists associates in providing quality, person-centered service...The service plan and services offered to the individual resident shall be appropriate to the scope, frequency, need, and preference of the resident. Service plans shall be reviewed and revised as appropriate and discussed with the resident and facility as needs or desires change...The service plan is reviewed and revised at a minimum of every 6 months or following a change in condition...."

This Citation relates to Complaint IN00452494.

Based on interview and record review, the facility failed to ensure a service plan for diabetes management was developed and implemented for 1 of 3 residents reviewed

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(Resident B).

Findings include:

1. On 2/18/25 at 11:16 A.M., Resident B's record was reviewed. Diagnoses included diabetes, chronic obstructive pulmonary disease, and chronic, recurring leg wounds.

A Service Plan for medication management, dated 3/20/24, indicated Resident B was independent with medication management. He was independent with self-administration of medications, was able to obtain new prescriptions, refills, and coordinate with lab appointments. He was on a medication with a possibility to cause bleeding/bruising and care staff were to report any changes.

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A physician progress note, dated 1/23/25 at 11:39 a.m., indicated Resident B was visited to follow up on acute and chronic issues with resultant hospitalizations the past month. The resident was diabetic and obese. During the visit, a discussion was had with the resident about diabetic medications to promote weight loss. The weight loss could help with his breathing but the resident was not interested. The resident was currently on insulin.

An Event Note, dated 1/27/25 at 4:04 p.m. and documented by Licensed Practical Nurse 2 (LPN), indicated Resident B reported his blood sugar was high at 479. The nurse texted the Nurse Practitioner (NP) and a new order was given to give 12 units of short acting insulin (Humalog). LPN 2 went to the resident's apartment to tell him of the new order and he informed her he had already taken 20 units of fast acting insulin (Fiasp). LPN 2 texted the NP and reported the resident had medicated himself and staff would monitor him.

The Service Plan hadn't indicated Resident B was prescribed insulin to manage diabetes.

A review of physician orders didn't indicate Resident B was

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prescribed insulin to manage his diabetes

The most recent completed self-administration of medication evaluation, dated 6/13/24, didn't indicate Resident B was prescribed insulin and his ability to safely administer the medication himself without supervision.

A Medication Administration Record (MAR), dated January 2025, indicated the resident had self-administered oral medications as ordered during the month and staff had provided ointments/creams to open areas on his legs. The MAR didn't indicate the resident was prescribed insulin or blood sugar monitoring.

On 2/18/25 at 1:14 P.M., the Administrator and Director of Nursing (DON) were interviewed. Both indicated they hadn't been made aware the resident was prescribed and taking insulin nor how long he had been taking the medication. They were unable to find orders for insulin and indicated if he had been prescribed insulin, a self-administration of medication evaluation would have needed to be completed and changes made to his service plan, if appropriate, prior to the resident self-administering the medication. When questioned, the DON indicated it would be

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important for staff to be aware he was taking insulin due to the effects of insulin lowering the blood sugar and an assessment completed to indicate the resident could safely administer the medication which was given subcutaneously.			
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This Citation relates to Complaint IN00452494.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S	TITLE Administrator/ED	(X6) DATE 04/04/2025
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SIGNATUREMary (Kathy) Bolling		
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