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	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NOBLE SENIOR LIVING AT FORT WAYNE	300 E WASHINGTON BLVD FORT WAYNE, IN 46802

(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 IN00365086. Complaint IN00365086 - Substantiated. State deficiencies related to the allegations are cited at R0090. Survey date: October 21, 2021 Facility number: 012288 Residential Census: 101 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 22, 2021	R 0000		
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: (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			

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

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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	(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 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 record review and interview, facility staff failed to immediately report resident abuse to administration for 1 of 1 concern. (Resident C) Findings include During record review, Incident Number 275 reported to the Indiana Department of Health (IDOH) indicated that on 10/11/21 at 2:15 P.M.,	R 0090	1.Administrator was notified 10/13/2021 by the CNA of the allegation of abuse. Facility reported incident to ISDH on 10/14/2021. 2.No other residents were affected as a result of an audit of reportable incidents.	10/22/2021

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	Employee 3 had brought Resident C to the nurses' station and asked her tell the other Certified Nursing Assistants (CNA) what Employee 3 did for a second job at night. Employee 3 then asked Resident C to demonstrate with gestures how to perform a certain sexual act. The investigation notes indicated staff present included Employee 1, Employee 2, Employee 4, Employee 5, and Employee 6. These staff failed to report immediately to administration, and did not report it until 10/13/21. During an interview on 10/21/21 at 11:15 A.M., the Director of Wellness/Nursing indicated during the investigation, staff who were present had said they did not feel it was any of their business and did not want to get involved since Employee 3 did not hit Resident C. She indicated all employees have had abuse training and were to report any alleged abuse immediately. The facility policy titled "Resident Abuse-Staff/Family," no date, no number, indicated "Policy and Procedure: ... 2. In other words, the resident has the right to be free from verbal, sexual, physical or mental abuse, ... This includes ... disrespectful or obscene language ... 5. Any suspected abuse is to be reported to the Administrator/Director immediately. ...." This State Residential tag relates to Complaint IN00365086.		3.Staff were in-serviced on the facility's 1.) Abuse/Neglect Reporting Guidelines and 2.) Resident Rights policy & procedures on 10/15/2021 by the DON. 4.The Director of Nursing, with oversight from the Administrator, will conduct monthly audits to ensure staff are aware of the facility's abuse/neglect reporting guidelines. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	