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	03/31/2021

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 Complaints IN00350009 and IN00350355. This visit was in conjuction with a Post Survey Revisit (PSR) to the Investigation of Complaints IN00337282, IN00338249, IN00339509, IN00339777, IN00339950, IN00340244, IN00340343, IN00340541, IN00340581, IN00343480, IN00343499, IN00343665, IN00345284, IN00345641, IN00346109, IN00346670, IN00347479, IN00347634, and IN00347764 and a Residential COVID-19 Quality Assurance Walk Through completed on February 23, 2021. Complaint IN00350009 - Substantiated. State Residential Findings related to the allegations are cited at R0147. Complaint IN00350355 - Substantiated. State Residential Findings related to the allegations are cited at R0052. Survey dates: March 29, 30, & 31, 2021 Facility number: 012288 Residential Census: 127 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 6, 2021	R 0000		
R 0052 Bldg. 00	410 IAC 16.2-5-1.2(v)(1-6) Residents' Rights - Offense (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse;			

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

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	(3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on interview and record review, the facility failed to ensure 1 of 2 residents reviewed were free from abuse. (Resident Z and Resident E) Findings include: The record review for Resident Z began on 3-31-2021 at 10:36 a.m. Diagnoses included but were not limited to, paralysis and weakness following a stroke affecting the right dominant side, other specified disorder of the brain, restless legs syndrome, osteoarthritis, nicotine dependence, and epilepsy. A review of the level of care assessment for Resident Z dated 2-11-2021, indicated the resident was oriented to person, place and time, decisions were poor, and required cueing and supervision in planning, organizing and correcting daily routines. A review of the progress notes for Resident Z dated 3-29-2021 at 8:53 a.m., indicated the Psych NP (Nurse Practitioner) saw the resident for an increase in anxiety and insomnia. The notes indicated the resident was not able to sleep at night, was anxious, worried, and unable to shut her mind down. The resident was started on Buspar 5 mg (milligrams) po (by mouth) three times a day for anxiety and Trazadone was increased to 100 mg po at bedtime to help with insomnia (sleeplessness). A progress note dated 3-24-2021 at 2:29 p.m., indicated Resident Z reported trouble sleeping at night due to the reported incident from the	R 0052	1.An immediate facility investigation was conducted on 3-23-2021 and Res E was arrested 3-23-2021 by the FWPD and pending charges. Res E will not be admitted back to the facility, and was permanently discharged from the facility on 3-31-2021. 2.No other residents voiced any concerns related to Res E, and Res E had no other reported incidents or concerns. All abuse allegations will be investigated and reported per the facility policy. 3.Res Z was encouraged to keep her door locked at all times. Residents were notified to keep doors locked at all times. Res E did not return to the facility and was permanently discharged from the facility. Staff were in-serviced 4-22-2021 by the Administrator on Abuse Prevention and Reporting protocol. 4.The Director of Nursing, with oversight from the Administrator, will conduct monthly audits to ensure incidents are investigated and reported to ISDH. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	04/22/2021

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	previous day. The NP was notified and Trazadone 50 mg po at bedtime for 2 weeks was ordered. The Pharmacy, DON (Director of Nursing) and ED (Executive Director) were notified. A progress note dated 3-23-2021 at 5:30 p.m., indicated Resident Z reported to staff, another resident was sexually inappropriate with her. The staff ensured Resident Z, was safe, reassured her of her safety, then assessed her for injury. Resident Z was provided with emotional support. The ED and DON were notified. The NP and the local police department were notified. On 3-29-2021 at 10:40 a.m., the DON provided a copy of the reportable incident sent to the State DOH (Department of Health). A review of the report indicated Resident E entered Resident Z's room on 3-23-2021 at 1:30 p.m. Resident Z indicated Resident E tried to rape her. The ED and DON were notified, the police were called and an investigation was completed. It was noted by the facility, the camera was reviewed and Resident E was seen on camera entering Resident Z's room about that time. The report indicated Resident E was arrested, his key was taken from his possession, and discharged from the facility as an emergency discharge. The facility provided follow up with Resident Z and the Psych NP was notified. Resident Z was offered a room move and encouraged to keep her door locked. On 3-30-2021 at 12:34 p.m., the DON provided investigation for the incident between Resident E and Resident Z. Resident Z indicated she was almost raped. The Administrator completed the investigation on 3-24-2021. She indicated in the report she had viewed the video of Resident E entering Resident Z's room on 3-23-2021 at 1:44:25 p.m., and exiting the room at 1:55:22 p.m. The			

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	police were contacted and Resident E was arrested on 3-23-2021 at 6:00 p.m. The detective on the case indicated Resident E admitted to most of the allegations. A no contact order was filed against Resident E and he will not be allowed to return to the facility premises. The investigation indicated Resident Z was provided emotional support, the Psych NP was notified and Resident Z was encouraged to keep door locked at all times. An interview with Resident Z on 3-31-2021 at 9:38 a.m., the resident's door was locked. After knocking, the resident answered the door. The resident indicated she was still having trouble sleeping after the male resident entered her room and tried to rape her. She indicated she still hears her door opening and was afraid to leave her room. She indicated she was keeping the door locked. An interview with Social Services 12 on 3-31-2021 at 9:45 a.m., indicated she had been talking with Resident Z and providing counseling and reassurance since the incident. A current "Abuse/Neglect" policy last revised on 11-28-2016 was provided by the DON on 3-31-2021 at 10:49 a.m. The policy indicated "...Each resident has the right to be free from abuse (...sexual...)...Residents must not be subjected to abuse by anyone, including, but not limited to...other residents...It is the policy of the facility, to ensure that each resident...will be free from abuse and neglect...." A current copy of the "Resident Rights Policy" dated 1-1-2020 and last reviewed on 4-1-2020 was provided by the DON on 3-31-2021 at 10:49 a.m. The policy indicated "...you have a right to be free from abuse...."			

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	This State Residential tag relates to Complaint IN00350355.			
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 observation, interview and record review, the facility failed to ensure resident smoking safety for 11 of 34 residents reviewed. (Resident C, Resident D, Resident H, Resident L, Resident AA, Resident R, Resident K, Resident BB, Resident CC, Resident DD and Resident HH) Findings include: A list of the current residents who smoked was provided by the facility on 3-29-2021 at 10:18 a.m. The list indicated 34 residents smoked. During an environmental tour on 3-29-2021 at 11:20 a.m., a stale cigarette odor was noted on the third floor. The Maintenance Director was observed to be cleaning out a vacated resident room, 314. An observation inside the room indicated there was a bedside table with over 20 cigarette butts on top of it. The top of the table finish was blackened as well as the side of the table. There was one 5 ounce bottle of lighter fluid on the bedside table and a can of butane lighter fluid on the floor. An interview with the Maintenance Director at this time, indicated the facility had cracked down on smoking. He indicated there was a point system. If a resident did not comply with the smoking rules, the	R 0147	1.Res C, D, H, L, AA, R , K, BB, CC, DD, and HH were issued verbal warnings regarding smoking policy non-compliance on 3-31-2021 by the FWFD and facility Management. Room 904 battery was replaced in the smoke detector. Smoking assessments were completed by the DON and designee on 4-16-2021 for residents identified who smoke. 2.Residents who are non-compliant with the facility's smoking policy were identified through an audit completed on 4-1-2021 by the IDT. Residents who smoke were identified through an audit completed by the DON 3-29-2021 3.The facility's smoking policy violation procedure was reviewed and revised by management on 3-31-2021. Residents were notified of the facility's smoking policy on 3-31-2021 by FWFD and facility management. Facility rounds will be completed by management on	04/22/2021

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	resident could be discharged from the facility. On 3-29-2021 at 11:32 a.m., upon entering the 10th floor an interview with a resident who wished to remain anonymous indicated they had witnessed residents smoke in their rooms. On 3-29-2021 at 11:37 a.m., the door to room 1021 was ajar. There was a strong odor of cigarette smoke coming from the partially opened door. Resident C answered the door. An observation inside Resident C's room indicated a lit cigarette was on the floor with smoke coming from the cigarette. Several cigarette butts were observed on the floor by the window. During an interview at this time with Resident C, he indicated he was smoking in his room, he knew he should not be smoking in his room, he was supposed to smoke outside in back in the smoking hut. Resident C indicated he knew he could not smoke in his room if he wanted to live in the facility. On 3-29-2021 at 11:49 a.m., upon entering the 9th floor, a high pitched chirping sound came from room 904. The chirping sound was observed to be coming from the smoke detector. The door to room 904 was open and no one was observed to be inside the room. An observation inside the room at this time indicated a ceramic bowl was on top of the beside table with 20 cigarette butts in the bowl and 6 cigarette butts on the floor between the bed and bedside table. A pack of cigarettes and a lighter were observed on the bedside table next to the ceramic bowl. An interview with Nurse 10 on 3-29-2021 at 11:52 a.m., indicated if she would find a resident smoking in their room, she would educate them about going outside and she would try to remove their cigarettes from them. She would also report		an ongoing basis, and concerns related to non-compliance with the smoking facility will be addressed on an individual basis. Smoke detectors will be tested by the Director of Maintenance or designee through the facility's preventative maintenance program. Staff were in-serviced 4-22-2021 by the Administrator on the facility's no smoking policy and staff responsibilities, to include staff protocol regarding the no smoking policy. 4.The IDT, with oversight from the administrator will conduct weekly audits to ensure residents are following the facility's smoking policy. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	

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	to the front desk as they keep a log of incidents. An interview with Fire Inspector on 3-30-2021 at 10:50 a.m., indicated there was a city ordinance which prohibits smoking inside the facility, no smoking was allowed outside within 20 feet from the entrance of the facility and 8 feet from any side or back entrances of the facility. The Fire Inspector indicated he had spoken with the ED (Executive Director) and she had set up a plan for violators of the smoking policy. The 1st offense, would be a $25 fine, the 2nd offense, would be a $250 fine, and the 3rd offense, the resident would be discharged from the facility. he indicated when the Fire Inspector was contacted, they could issue a $100 citation to the facility. An observation of Resident H's room with the Fire Inspector on 3-30-2021 at 1:08 p.m., indicated a noticeable cigarette smoke odor was in the room. Resident H was observed in his bed. A ceramic bowl of cigarette butts was observed on the bedside table with some cigarette butts observed on the floor. The Fire Inspector spoke to the resident and asked him about smoking in his room. The resident indicated he would break off the cigarette butt from the rest of the cigarette and place the butts in the dish. The resident indicated he would take the rest of the cigarette outside to smoke. There were some cigarette butts with blackened ends and ashes observed in the dish. There was a cup with water on the bedside table observed with several cigarette butts in the water with blackened ends. The resident was educated by the Fire Inspector about the smoking policy of the facility - smoking was prohibited in resident rooms and the designated smoking area was the smoking hut outside the facility. An observation and interview with Resident D on			

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	3-30-2021 at 1:17 p.m., indicated the resident was educated by the Fire Inspector about not smoking in her room. The resident indicated her smoking materials were at the front desk. The Fire Inspector educated the resident on the designated smoking area and to not smoke just outside the facility doors. An observation and interview with Resident C on 3-30-2021 at 1:21 p.m. The Fire Inspector educated the resident about the smoking policy. The Fire Inspector pointed out a cigarette butt on top of a sock hat on the floor was a fire hazard. Cigarette butts observed in a dust pan had black ashes. A table in front of the window was observed with round, small, black, burned circles on the top of the table. The Fire Inspector indicated the marks were burn marks on the table and the resident agreed. Black ashes were observed on the floor. The Fire Inspector educated the resident about not smoking in his room and indicated the only designated smoking area was the smoking hut in the back parking lot of the facility. An observation with the Fire Inspector on 3-30-2021 at 1:23 p.m., indicated Resident L's room door was unlocked and Resident L was not in the room. The Fire Inspector entered the room. We observed black ashes on the bedside table. The Fire Inspector performed a successful test on the smoke alarm. In an interview on 3-30-2021 at 1:27 p.m., CNA 13 (Certified Nurse Aide) indicated if she were to observe a resident smoking in the facility, she would let someone know and explain to the resident they were not supposed to smoke in their room. She indicated she would also check their trash to ensure the cigarette butts were out.			

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	On 3-30-2021 at 1:35 p.m., the Fire Inspector was observed to speak with the ED. He indicated since the facility was going to crack down on this smoking in the building, then the facility would need to track the residents and their violations. The Fire Inspector also indicated instead of staff sitting at a station, the staff should be routinely patrolling the halls. An interview with the ED on 3-30-2021 at 1:43 p.m., indicated all the residents choosing to smoke had been educated on the new process and staff were educated to confiscate smoking material if residents were found smoking in their room or in the facility. She indicated residents and staff were educated the only designated smoking area was the smoke hut on the back parking lot of the facility. An observation of the ED and Fire Inspector indicated they made rounds to some additional rooms for the Fire Inspector to educate residents on the smoking policy. The following residents were observed being educated: On 3-30-2021 at 1:45 p.m., Resident AA was educated. On 3-30-2021 at 1:52 p.m., Resident R was not in her room, but a a full ashtray and strong cigarette smoke odor was noted in the room. On 3-30-2021 at 1:54 p.m., Resident K was not in her room. A cup being used as an ashtray was observed in the room. On 3-30-2021 at 1:55 p.m., Resident BB was educated. On 3-30-2021 at 1:59 p.m., A strong cigarette smoke odor was noted in Resident CC's room. On 3-30-2021 at 2:01 p.m., Resident DD was educated. An observation of Resident H on 3-30-2021 at 3:09			

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	p.m., indicated he was walking towards the back entrance from the lobby front desk. The resident was observed trying to open the secured door while he was holding a lit cigarette in his left hand. The resident asked the surveyor if she could open the door. The front desk staff was notified Resident H was at the back door with a lit cigarette in his hand and was trying to get out the locked door. The front desk staff member came around and proceeded toward the resident. The front desk staff indicated the resident should have not lit the cigarette and he should have waited until he got outside of the building. The record review for Resident C began on 3-29-2021 at 2:39 p.m. Diagnoses included but were not limited to schizoaffective disorder depressive type, alcohol abuse, high blood pressure, unspecified intellectual disabilities, anxiety, and non-compliance with other medical treatments and regiment. A smoking assessment for Resident C was not located in the resident's record. A quarterly Level of Care assessment dated 2-11-2021 for Resident C, indicated the resident was oriented to person, place and time, judgment was rated a 3, as decisions were poor, required cueing and supervision in planning, organizing and correcting daily routines. The record review for Resident D began on 3-30-2021 at 12:27 p.m. Diagnoses included but were not limited to, Parkinson's Disease, schizophrenia, bipolar disorder, chronic obstructive pulmonary disease, anxiety, high blood pressure, and depression. A level of care assessment dated 2-11-2021 for			

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	Resident D indicated the resident was oriented to person, place and time and judgement was rated a 3 as decisions were poor, required cueing and supervision in planning, organizing and correcting daily routines. A smoking assessment for Resident D was not located in the resident's record. The record review for Resident L began 3-30-2021 at 12:45 p.m. Diagnoses included but were not limited to, alcohol abuse, chronic pain syndrome, bipolar disorder, depression, paranoid schizophrenia and psychoactive substance abuse. A level of care assessment dated 11-17-2020 for Resident L indicated the resident was oriented to person, place and time and judgement was rated a 3 as decisions were poor, required cueing and supervision in planning, organizing and correcting daily routines. A smoking assessment for Resident L was not located in the resident's record. A review of Resident L's progress notes indicated on 3-27-2021 at 11:44 a.m., an incident report was entered for this resident. Resident L was observed in another resident's room. The room was full of smoke and Resident L had a cigarette lighter in his hand. The other resident was sleeping per the report at the time. The record review for Resident H began on 3-30-2021 at 12:54 p.m. Diagnoses included but were not limited to, cerebral infarction, pseudobulbar affect, high blood pressure, diabetes, and muscle weakness. A level of care assessment dated 2-1-2021			

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	indicated the resident was oriented to person, place and time and judgement was rated a 3 as decisions were poor, required cueing and supervision in planning, organizing and correcting daily routines. A smoking assessment for Resident H was not located in the resident's record. On 3-30-2021 at 1:30 p.m., the DON (Director of Nursing) provided signed smoking policy for Resident L dated 11-17-2020, for Resident H dated 12-30-2020 and for Resident C dated 10-9-2020. The DON indicated the facility did not have smoking assessments for Resident C, Resident D, Resident H and Resident L. On 3-30-2021 at 2:27 p.m., the DON provided the signed smoking policy for Resident D dated 1-22-2019. An interview with the DON on 3-30-2021 at 2:28 p.m., indicated the facility was not doing smoking assessments for residents unless they needed assistance with smoking. The DON was interviewed regarding the current smoking policy which indicated residents will be assessed for smoking privileges. The DON indicated the facility would have to add this assessment to the list. A copy of the Front Desk Incident Log was provided by Receptionist 14 on 3-31-2021 at 9:05 a.m. The Incident Log indicated Resident HH was reported to be smoking in her room on 3-29-2021 and Resident H was observed with a lit cigarette inside the lobby on 3-30-2021. A copy of an Occurrence Violation form was provided by the facility on 3-30-2021 at 11:00 a.m.			

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NOBLE SENIOR LIVING AT FORT WAYNE	300 E WASHINGTON BLVD FORT WAYNE, IN 46802

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	and indicated the following: "...It has been reported that you have violated the Facility's and/or City Ordinance by refusing to smoke in the designated smoking areas designated by the facility. This letter serves as your official notice of violation of the smoking policy. 1st Occurrence-Written Warning Letter $25.00 Fine charged/each Occurrence to resident's account Aging and In-Home Case Manager Notified 2nd Occurrence-Written Warning Letter $250 Smoking Fine charge to resident's account Aging and In-Home Case Manager Notified 3rd Occurrence-Final Notice 30 Day Discharge Notice issue to Resident Aging and In-Home Case Manager Notified...." An current, undated copy of the "Smoking Policy" was provided by the ED on 3-29-2021 at 3:59 p.m. The Smoking Policy indicated, "...It is the intent of the Community to allow those residents who wish to smoke, the opportunity to do so in an environment with optimal safety to themselves, other residents, visitors and staff members. Resident agrees to abide by the following rules regarding smoking at this Community: Resident agrees he or she will smoke only in designated areas at the Community...Residents will be assessed for smoking privileges...If the resident is caught smoking in the facility, the community will assess the resident a $25.00 violation for each occurrence...Continued non-compliance of the community's smoking policy will result in discharge from of <sic> the resident from the community. When smoking in designated areas, Resident will properly dispose of cigarette butts and packaging in appropriate receptacles...If Resident violates this Smoking			

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	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Policy or any other smoking rules and regulations of the Community, whether communicated to Resident verbally or in writing, it may be grounds for eviction...." This deficiency was cited on February 23, 2021. The facility failed to implement a systemic plan of correction to prevent recurrence. This State Residential tag relates to Complaint IN00350009.			