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

FORM APPROVED
OMB NO. 0938-039

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	04/06/2023

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 a State Residential Licensure Survey. Survey dates: April 3, 4, 5, and 6, 2023. Facility number: 012288 Residential Census: 76 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 10, 2023	R 0000		
R 0144 Bldg. 00	410 IAC 16.2-5-1.5(a) Sanitation and Safety Standards - Deficiency (a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure repairs after water damage were completed for the 8th floor. 5 of 76 residents resided on the 8th floor. Findings include: An observation of the 8th floor on 4-4-23 at 9:20 AM, indicated throughout the entire hallway, no covebase was on throughout the hallway, all areas were open. There were various round sized holes in the drywall throughout the hallway. In an interview on 4-6-23 at 10:08 AM, the Maintenance Director indicated they had water damage last year. this necessitated the removal of	R 0144	1. -The cove base was replaced on the 8th floor hallway and the water damage was repaired on 4/6/23 by the Maintenance Director. 2. -An audit was completed of the facility on 4/17/23 to identify any other areas in the facility requiring repairs. Any areas identified as a result of the audit have been addressed or put on the facility's preventative maintenance schedule to be repaired.	04/24/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jina Babani	Administrator	04/27/2023

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 covebase. They contacted a contractor, so they had been waiting for them to finish. He indicated the facility had a work order. In an interview on 4-6-23 at 10:32 AM, the Executive Director indicated all she had was the form she contacted the contractor. She indicated she didn't have a work order or purchase order. A request for a policy for repairs was requested, but was not received by the time surveyors exited facility. The form dated 5-24-2022 was provided by the Maintenance Director. The form indicated a proposal: painting request. Product/services proposed: drywall patches and infill's: provide and install drywall to patch/infill where missing, locations: 8th floor. No work or purchase order was availabole by time of exit.		3. -The IDT was in-serviced by the RCA on 4/24/23 on ensuring that the facility is maintained in a state of good repair, and to ensure repairs are completed in a timely manner. 4. The Maintenance and Housekeeping Directors, with oversight from the Administrator, will conduct daily audits of the facility to identify and address any areas of concerns with the physical environment. The findings from the audits will be reviewed during the facility’s Monthly QAPI meeting until there is 100% compliance.	
R 0216 Bldg. 00	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.			

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	Based on interview and record review the facility failed to monitor weight routinely for 1 of 7 residents reviewed. (Resident 5) Findings include: During an interview on 4/3/23 at 10:18AM Resident 5 indicated the facility now had health fairs every other week. She indicated the residents could get vitals signs including weight done then. Resident 5 indicated the facility did not weigh her consistently in the past. Resident 5's record review began on 4/3/23 at 1:16PM, indicated her diagnosis included congestive heart failure, respiratory failure with hypoxia, hypertension, type 2 diabetes, morbid obesity, anxiety, and major depressive disorder. A copy of Resident 5's weights were received from the ADON (Assistant Director of Nursing) on 4/4/23 at 12:25PM. Weights were recorded as follows. 11/8/21 282 1/24/23 240.2 2/14/23 282.4 3/25/23 275.2 There were no weights available to review between 11/8/21 and 1/24/23. No policy or procedure was available at exit regarding resident weights.	R 0216	1.Res #5 weight has been taken monthly on 1/24/23, 2/14/23, and 3/25/23. Res #5 has been LOA from facility since 4/3/23 and will be weighed by nursing staff upon her return from LOA. 2. -An audit of residents weights was completed by Nurse Management on 4/11/23. There were no other residents found from the audit to have not had a weight on record within the last 6 months. 3. -Nursing staff were in-serviced on 4/24/23 by the ADON; Resident weights are to be completed no less than every 6 months. -A wellness clinic has been conducted each month since 4/1/23, where the resident's weights are taken and recorded by the nursing staff in the resident's clinical record. 4.The ADON, with oversight from the DON, will conduct monthly audits to ensure resident weights are taken and recorded in the residents charts on a monthly basis. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	04/24/2023
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with			

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	activities of daily living, shall be provided based upon individual needs and preferences. Based on observation, interview and record review. The facility failed to ensure physician orders were followed for 1 of 5 residents. Resident 17. Findings include: During an observation on 4-4-23 at 1:04 PM, Qualified Medication Aide (QMA) 1 was assisting a resident during medication pass. Resident 17 came into the nurse's office and asked to speak to the QMA regarding her medication changes. Resident 17 proceeded to explain, she was still receiving certain medications that were supposed to be changed. One medication included Olanzapine. She indicated she should only be getting one tabley and they are still giving her two. She indicated Geodon was supposed to be discontinued, but she was still receiving it. QMA 1 asked if the medications were changed last Friday. Resident 17 indicated yes. The QMA asked Resident 17 what she was doing with those medications. Resident 17 indicated she was throwing them away in the trash. Resident 17 indicated she went to her doctor last week, brought back the paperwork and gave it to QMA 1. QMA 1 indicated she gave the paperwork to the Director of Nursing (DON) as she is not allowed to make any changes, only a licensed nursee could make changes to the physician orders. The Assistant Director of Nursing (ADON) was called into the office. ADON looked into the record of Resident 17. In the record, there was a physician note dated 3-29-23 at 12:03 PM, indicated a change to the following medications: Olanzapine 20 milligrams (mg) at bedtime and Geodon had been discontinued. The ADON	R 0240	1. -Resident # 17 Geodon was discontinued on 4/4/23. Resident #17 physician was notified. 2. -An audit of residents physician orders was initiated 4/7/23 and is ongoing, to double check that residents physician orders are being entered into the residents' EMR with accuracy. 3. -Nurses were in-serviced on 4/24/23 by the ADON, on the facility's protocol for processing and receiving physician's orders; Nurses will be required to complete a two-step process when reviewing and entering physician's orders in the residents' EMR for accuracy. 4.The ADON, with oversight from the DON, will conduct monthly audits to ensure residents physician's orders are double checked and entered in the residents' EMR for accuracy. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	04/24/2023

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	looked at the current physician orders. She indicated the Olanzapine 20 mg was changed but the Geodon was not, there were two orders regarding this medication. One was for 40 mg to be given at bedtime and the second one was 20 mg both to be given in the morning. QMA 1 indicated she found the Olanzapine medication packet in the medication cart. The medication packet was observed to have 2 tablets, 20 mg each. the QMA indicated Resident 17 was still receiving 2 tablets instead of one. The ADON indicated she would call the doctor to clarify the order. She indicated staff should have followed up to clarify the order when it was received. Because of this Resident 17 was throwing away medication instead of returning the medication back to the pharmacy. Resident 17's record review began on 4-5-23 at 12:04 PM, diagnosis included, Bipolar disorder, generalized anxiety disorder, and depression. A physician order dated 3/29/23 for Olanzapine 20 mg indicated to give 1 tablet by mouth at bedtime for depression. An observation of the Olanzapine medication packet on 4/5/23 indicated the medication packet with 2 tablets was still in the medication cart. The new order was not being follow by staff and Resident 17 was still being given two 20 mg tablets instead of one. A physician order for Ziprasidone (Geodon) HCL oral capsule 20 mg indicated to give 20 mg by mouth in the morning for Bipolar disorder. This medication was discontinued on 4/4/23 and not on 3/29/23 as ordered. A physician order for Ziprasidone (Geodon) HCL			

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	oral capsule 40 mg indicated to give 20 mg by mouth at bedtime for Bipolar disorder. This medication was discontinued on 4/4/23 and not on 3/29/23 as ordered. A record review of the Medication record administration (MAR) dated March 2023, indicated Resident 17 was given the medication Ziprasidone 20 mg in the morning for the following dates: 30, and 31. A record review of the MAR dated April 2023, indicated Resident 17 was given the medication Ziprasidone 20 mg in the morning for the following dates: 1, 2, and 3. A record review of the MAR dated March 2023, indicated Resident 17 was given the medication Ziprasidone 40 mg at bedtime for the following dates: 30 and 31. A record review of the MAR dated April 2023, indicated Resident 17 was given the medication Ziprasidone 40 mg at bedtime for the following dates: 1, 2, and 3. A record review of the MAR dated March 2023, indicated Resident 17 was given the medication Olanzapine 20 mg at bedtime for the following dates: 30 and 31. A record review of the MAR dated April 2023, indicated Resident 17 was given the medication Olanzapine 20 mg at bedtime for the following dates: 1, 2, and 3. A review of a progress note dated 4/4/23 at 2:17 PM indicated a message was left with the physician to clarify the medication changes. There were no other progress notes between March 29th			

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	through 4/4/23 to indicate someone attempted to clarify the changes. In an interview on 4/5/23 at 9:05 AM, the ADON indicated she was still waiting for a phone call back to clarify the changes. She had not destroyed or sent back the medications, as she was new and was not sure what to do to remain compliant with the policy. A current facility policy, Medication orders, dated January 2007, was provided by the ADON on 4-5-23 at 12:04 PM. The policy indicated ..." Medication are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe ...The prescriber is contacted to verify to clarify an order (e.g., when the resident has allergies to the medication, there are contraindication to the medication, the directions are confusing) ..			
R 0295 Bldg. 00	410 IAC 16.2-5-6(a) Pharmaceutical Services - Noncompliance (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents.			
	Based on observation, interview, and record review the facility failed to ensure a resident who self-administered medication was safely storing medications for 1 of 2 residents reviewed. (Resident 5) Findings include: During an observation of Resident 5's living area, on 4/3/23 at 10:05 AM, her door was not locked upon us arriving together. Near her window there were 2 brown paper bags, grocery size, overflowing with filled bubble wrapped pill	R 0295	1. -Resident # 5 door was locked by the ADON on 4/6/23. -Res # 5 has been LOA from the facility since 4/3/23 and will be re-assessed by nursing upon return from LOA to ensure resident is safe to continue to self-administer medications and can store them properly in the resident's room. -Resident # 5 was educated on 4/25/23 by the DON on ensuring	04/25/2023

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	containers. The containers were visible from the entry of apartment. During an interview on 4/3/23 at 10:09 AM, Resident 5, indicated she received her medications a week at a time. She indicated she was stocked piled because of hospital stays. Resident 5 indicated the extra meds came in handy for week long visits to her daughters. Resident 5 did not indicate staff requested extra medications to be stored securelyl. Resident 5's record review began on 4/3/23 at 1:16PM. Her diagnosis included congestive heart failure, respiratory failure with hypoxia, hypertension, type 2 diabetes, morbid obesity, anxiety, and major depressive disorder. Self-administration of medication assessments were documented on 3/17/21 and 3/27/23. During an interview on 4/6/23 at 9:39AM, the DON (Director of Nursing) indicated housekeeping and CNAs (Certified Nurse Aid) were expected to be watchful for medication stock piling while providing services in the resident rooms and report to a licensed nurse. A policy titled; "Medication Assistance" was provided by ADON (Assistant Director of Nursing) on 4/6/23 at 12:00 PM no date of policy available. The policy indicated, "A. 1) Residents who self-administer medications, are required to secure their medications in a safe and secure site for medication storage in their locked unit."		medications in Res #5 room are secured and locked at all times, and that Resident cannot stockpile medications in the room. 2. -An audit of resident's who self-administer their medications was completed on 4/23/23 by the DON and/or designee to ensure the residents who self-administered medications are secured and locked. Any findings as a result of the audit were addressed at that time. 3. -Nursing and ancillary staff were in-serviced on 4/24/23 by the ADON, on ensuring residents who self-administer medication are securing their medications in their rooms by locking their door at all times, to include, notifying the nurse of a resident who is stockpiling medications in their room. 4. The ADON, with oversight from the DON, will conduct daily audits to ensure residents who self-administer their medications are securing their medications, to include, not stockpiling resident medications their room. The findings from the audits will be reviewed during the facility's quarterly QAPI meeting until there is 100% compliance.	