STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155798	A. BUILDING -- B. WING	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ASHTON CREEK HEALTH AND REHABILITATION CENTER	4111 PARK PLACE DRIVE FORT WAYNE, IN 46845

(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
E 0000 Bldg. --	A Post Survey Revisit (PSR) to the Emergency Preparedness Survey conducted on 07/19/23 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/06/23 Facility Number: 012861 Provider Number: 155798 AIM Number: 201080610 At this PSR survey, Ashton Creek Health and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 139 and had a census of 108 at the time of this survey. Quality Review completed on 09/08/23	E 0000	N/A	
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 07/19/23 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a). Survey Date: 09/06/23 Facility Number: 012861 Provider Number: 155798 AIM Number: 201080610 At this PSR survey, Ashton Creek Health and	K 0000	N/A	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Derek Gibson		09/19/2023

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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	Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 139 and had a census of 108 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 09/08/23			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances,			

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	secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation, records review, and interview, the facility failed to enforce 1 of 1 non-smoking policies. This deficient practice could affect staff that use the employee entrance/exit. Findings include: Upon arrival to the facility on 09/06/23 at 11:00 a.m., a staff member was observed smoking by the storage shed. Based on observations with the Maintenance Director at 11:30 a.m., smoking on property was evident due cigarette butts on the ground outside of the service hall. Based on records review at 11:30 a.m., the smoking policy stated, "Tobacco use is prohibited throughout the campus." Based on interview at the time of observation and records review, the Maintenance Director stated the facility is still a non-smoking campus and confirmed there was smoking on property by staff. The findings were reviewed with the Administrator and the Maintenance Director during the exit conference.	K 0741	1. The entire property was cleaned of cigarette butts immediately. No residents were affected. 2. No other residents had the potential to be affected. This deficient practice could affect staff that use the employee entrance by the service hall. 3. All staff were re-inserviced on the facility's non-smoking policy. An audit will be completed 2x daily for 8 weeks, 1x daily for 4 weeks, 3x per week for 2 weeks, and then weekly until 100% compliance is achieved. 4. Results of these audits will be reviewed in a weekly QAPI meeting for 6 months until 100% compliance is achieved and adjustments will be made accordingly.	09/19/2023

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	This deficiency was cited on 07/19/23. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-19(b)		5. Systemic changes for deficiency will be completed by 9/19/2023.	