

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 11/01/2023	
NAME OF PROVIDER OR SUPPLIER AUBURN SENIOR LIVING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1675 W SEVENTH STREET, AUBURN, , 46706					
(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 Complaint IN00420396. Complaint IN00420396 - State deficiencies related to the allegations are cited at R0214 and R0270. Survey date: November 1, 2023 Facility number: 014775 Residential Census: 74 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed November 2, 2023	R 0000					
R 0214	Evaluation - Deficiency 410 IAC 16.2-5-2(a) (a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least	R 0214	1 Resident D and F have had updated assessments completed, and service plans changed as needed.			12/06/2023	

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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 observation, interview and record review, the facility failed to re-assess and evaluate resident needs following a significant change in condition for 2 of 3 residents reviewed (Resident D and Resident F).

Findings include:

1. On 11/1/23 at 12:22 P.M., Resident D was observed seated in the memory care unit dining room. His affect was flat and he stared out in front of him. There were 3 separate bowls of food sitting in front of him on the table but he made no attempt to eat.

On 11/1/23 at 12:45 P.M., Resident D's record was reviewed. Diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, or mood disturbance and anxiety.

An admission Assisted Living Assessment, dated 6/10/23, indicated the following:

-Resident was not always oriented.

-He was capable of independent decision making and had no

2 An audit will be completed on all current residents and there assessments. Any noted residents with significant changes will be reassessed and service plans changed appropriately.

3 The Resident Service Director or designee will ensure that all evaluations of residents will be initiated at admission, semiannually, upon a substantial change or per request of facility or resident. All nursing associates were given an in-service on 11.08.23 regarding the protocols for evaluations and the criteria that constitutes a substantial change in condition. Resident service director, or designee will monitor the completion of evaluations for all residents residing in the facility as well as all new admissions for the next 30 days.

4 Resident service plans will be reviewed and trended in the community's weekly risk

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behaviors.

-He was on a general diet, regular consistency with thin liquids.

-He required standby assistance and cues with bathing, dressing, and grooming.

-Resident was totally continent of bladder, continent of bowel and was independent with using the bathroom.

A Service Plan, initiated on 6/19/23 and revised 7/24/23, indicated the following:

-The resident would be supported to make appropriate decisions about his care and environment. He had moderate dementia with significant short-term memory and possibly long term memory loss. Staff were to provide reminders for activities and meals.

-7/24/23: Dementia Behaviors: the resident would be able to identify factors/interventions that helped to prevent/minimize inappropriate behaviors. Staff were to report changes from baseline behaviors to the nurse and he would be allowed to wander but wasn't a disturbance to others.

-The resident would maintain appropriate weight and nutritional status. Staff would provide a general diet, regular

meetings. Areas of concern will be addressed timely.

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consistency with thin liquids;
food and fluids would be
encouraged and reminders
given to go to the dining room
for meals.

-The resident would have his
activities of daily living met. Staff
would assist with dressing,
grooming, personal hygiene,
and oral care.

-The resident would maintain
independence for toileting.

Progress notes indicated the
following:

-8/31/23 at 7:19 p.m., the
medical NP indicated the
resident was seen for increased
verbal outbursts. Nursing had
tried to obtain a urinalysis but
were unable to do so because
the resident was incontinent.

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-9/15/23 at 11:30 a.m., a psychiatric NP note indicated the resident was visited. Since admission, the resident had some difficulty adjusting and had been having verbal outbursts. During the visit, he was delusional with some paranoia, affect was flat, and he had difficulty finding words. He was assessed as having moderate dementia with psychotic disturbance, major depressive disorder, and anxiety. He was to continue on his current medications to treat his dementia, depression, and anxiety.

-9/21/23 at 5:13 p.m., the medical NP indicated the resident was seen for frequent coughing when eating, signs and symptoms of aspiration. His diet was changed to mechanical soft with ground up meat and speech therapy was to evaluate and treat the resident.

-10/7/23 at 7:38 p.m., the resident slapped the CNA (Certified Nurse Aid) while being assisted to toilet.

-10/8/23 at 2:12 p.m., the resident threw a cup of water at the QMA (Qualified Medication Aid) and spit out his medications. He was very agitated with staff and told them to get out of his room.

-10/9/23 at 6:08 p.m., the

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resident called the CNA over to him and punched her in the stomach.

-10/17/23 at 10:01 p.m., the resident had been agitated, restless, yelling at others, and throwing food at another resident during supper.

-10/19/23 at 2:35 p.m., the resident was very agitated at lunch. Redirection was not effective and the resident swung at and cursed at staff. He refused breakfast and lunch.

-10/25/23 at 7:04 p.m., the resident refused supper and had been very teary.

-10/26/23 at 3:39 p.m., the medical NP visited and indicated the resident had lost 7 pounds over the past month. He was less active and not eating well. The plan was to start another anti-depressant medication to help with his appetite.

-10/27/23 at 3:20 p.m., the resident was incontinent of bladder and when staff tried to change him, he came at staff very agitated and confrontational. The psychiatric NP was notified and orders given to start resident on an anti-psychotic medication for behaviors.

Review of resident weights indicated significant weight

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changes from month to month.
The resident's admission weight was 163 with his current weight dated 11/1/23 being 122.4; a 41 pound loss in 5 months.

There was no re-assessment or evaluation completed following the residents significant change in weight, increasing behaviors, new onset bladder incontinence, change in diet due to signs/symptoms of aspiration, and new use of anti-psychotic medications. There was no documentation to indicate speech therapy had evaluated/treated the resident as recommended by the medical NP on 9/21/23.

2. On 11/1/23 at 12:20 P.M., Resident F was observed in the memory care unit dining room. On his plate, were clumps of a breaded meat patty covered with a white thick gravy. He was observed to eat a third of the meat and was coughing as he swallowed the food. He got up from the table leaving most of his lunch on the plate.

On 11/1/23 at 11:30 A.M., Resident F's record was reviewed. Diagnoses included Alzheimer's disease and aspiration pneumonia (occurs when food or liquid is breathed into the lungs instead of being swallowed).

A Semi-Annual Assisted Living

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Assessment, dated 7/11/23, indicated the resident required reminders and cues for dining assistance. His diet order was left blank and not listed.

A Service Plan, last reviewed on 7/11/23, indicated the resident would maintain appropriate weight and nutritional status. Staff were to provide a general diet with regular texture and liquids thin in consistency. Staff were to remind him to go to meals where he was independent with eating and drinking. Staff were to encourage fluid and food consumption.

A Nurse Practitioner (NP) progress note, dated 10/12/23 at 12:47 p.m., indicated the resident had been taken to the hospital for acute respiratory distress and was treated for aspiration pneumonia with antibiotics. Speech therapy performed an evaluation and placed the resident on a regular diet with ground meat. The resident was only eating about 20% of his meals. He was able to drink thin liquids without signs/symptoms of aspiration. He needed follow up with speech therapy.

There was no re-assessment or evaluation completed following the residents significant change in diet, recent aspiration pneumonia with hospitalization,

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or decrease in eating meals.
There was no documentation of speech therapy follow up and recommendations.

On 11/1/23 at 4:03 P.M., the Administrator indicated resident's were to have an assessment and service plan review upon significant changes in their condition. She provided a current facility policy, titled "Service Plans" . The policy indicated; "A resident centered service plan is created and maintained for every resident. The purpose of the service plan is to provide a centralized coordination of the services that will be provided to each resident, based on their individual needs, abilities, and preferences...Formal review takes place...d. Upon significant change in resident status/condition".

This citation relates to Complaint IN00420396.

Based on observation, interview and record review, the facility failed to re-assess and evaluate resident needs following a significant change in condition for 2 of 3 residents reviewed (Resident D and Resident F).

Findings include:

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An admission Assisted Living Assessment, dated 6/10/23, indicated the following:

-Resident was not always oriented.

-He was capable of independent decision making and had no behaviors.

-He was on a general diet, regular consistency with thin liquids.

-He required standby assistance and cues with bathing, dressing, and grooming.

-Resident was totally continent of bladder, continent of bowel and was independent with using the bathroom.

A Service Plan, initiated on 6/19/23 and revised 7/24/23, indicated the following:

-The resident would be supported to make appropriate

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decisions about his care and environment. He had moderate dementia with significant short-term memory and possibly long term memory loss. Staff were to provide reminders for activities and meals.

-7/24/23: Dementia Behaviors: the resident would be able to identify factors/interventions that helped to prevent/minimize inappropriate behaviors. Staff were to report changes from baseline behaviors to the nurse and he would be allowed to wander but wasn't a disturbance to others.

-The resident would maintain appropriate weight and nutritional status. Staff would provide a general diet, regular consistency with thin liquids; food and fluids would be encouraged and reminders given to go to the dining room for meals.

-The resident would have his activities of daily living met. Staff would assist with dressing, grooming, personal hygiene, and oral care.

-The resident would maintain independence for toileting.

Progress notes indicated the following:

-8/31/23 at 7:19 p.m., the medical NP indicated the resident was seen for increased

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-10/27/23 at 3:20 p.m., the resident was incontinent of bladder and when staff tried to change him, he came at staff very agitated and confrontational. The psychiatric NP was notified and orders given to start resident on an

anti-psychotic medication for behaviors.

Review of resident weights indicated significant weight changes from month to month. The resident's admission weight was 163 with his current weight dated 11/1/23 being 122.4; a 41 pound loss in 5 months.

There was no re-assessment or evaluation completed following the residents significant change in weight, increasing behaviors, new onset bladder incontinence, change in diet due to signs/symptoms of aspiration, and new use of anti-psychotic medications. There was no documentation to indicate speech therapy had evaluated/treated the resident as recommended by the medical NP on 9/21/23.

2. On 11/1/23 at 12:20 P.M., Resident F was observed in the memory care unit dining room. On his plate, were clumps of a breaded meat patty covered with a white thick gravy. He was observed to eat a third of the meat and was coughing as he swallowed the food. He got up from the table leaving most of his lunch on the plate.

On 11/1/23 at 11:30 A.M., Resident F's record was reviewed. Diagnoses included Alzheimer's disease and aspiration pneumonia (occurs

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when food or liquid is breathed into the lungs instead of being swallowed).

A Semi-Annual Assisted Living Assessment, dated 7/11/23, indicated the resident required reminders and cues for dining assistance. His diet order was left blank and not listed.

A Service Plan, last reviewed on 7/11/23, indicated the resident would maintain appropriate weight and nutritional status. Staff were to provide a general diet with regular texture and liquids thin in consistency. Staff were to remind him to go to meals where he was independent with eating and drinking. Staff were to encourage fluid and food consumption.

A Nurse Practitioner (NP) progress note, dated 10/12/23 at 12:47 p.m., indicated the resident had been taken to the hospital for acute respiratory distress and was treated for aspiration pneumonia with antibiotics. Speech therapy performed an evaluation and placed the resident on a regular diet with ground meat. The resident was only eating about 20% of his meals. He was able to drink thin liquids without signs/symptoms of aspiration. He needed follow up with speech therapy.

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	There was no re-assessment or evaluation completed following the residents significant change in diet, recent aspiration pneumonia with hospitalization, or decrease in eating meals. There was no documentation of speech therapy follow up and recommendations. On 11/1/23 at 4:03 P.M., the Administrator indicated resident's were to have an assessment and service plan review upon significant changes in their condition. She provided a current facility policy, titled "Service Plans" . The policy indicated; "A resident centered service plan is created and maintained for every resident. The purpose of the service plan is to provide a centralized coordination of the services that will be provided to each resident, based on their individual needs, abilities, and preferences...Formal review takes place...d. Upon significant change in resident status/condition". This citation relates to Complaint IN00420396.			
R 0270	Food and Nutritional Services - Deficiency 410 IAC 16.2-5-5.1(c)(1-3) (c) The facility must meet: (1) daily dietary requirements and	R 0270	1 Resident B's diet order has been clarified with the physician and updated on the service plan as appropriate. The Dining Service Director or designee will ensure residents	12/06/2023

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FORM APPROVED

OMB NO. 0938-0391

requests, with consideration of food allergies;

(2) reasonable religious, ethnic, and personal preferences; and

(3) the temporary need for meals delivered to the resident ' s room.

Based on observation, interview and record review, the facility failed to ensure resident's daily dietary requirements and requests were met for 2 of 3 residents reviewed (Resident B and Resident F).

Findings include:

1. On 11/1/23 at 10:10 A.M., Resident B's family member was interviewed. She indicated concerns with the consistency of the residents food. The resident had 2 serious episodes of choking on food the previous year and required a mechanical soft diet with ground meat. The family member alleged the resident was not consistently receiving ground meat at each meal and was at continued risk of choking. She indicated she had filed grievances for 2 incidents in October when the resident's meat had not been ground up or had only been partially ground.

daily dietary requirements to include supplements if applicable, requests, and physician ordered diet are met. The dietary department will also ensure that the physician's dietary orders are being followed as prescribed.

Resident B and F diet orders have been clarified with the physician and service plan updated as appropriate.

2 Residents with therapeutic diets have the potential to be impacted, however no negative outcomes were noted after an audit of therapeutic diet orders was completed.

3 The Dining Service Director or designee will ensure residents daily dietary requirements to include supplements if applicable and resident requests are met. The Dining Service Director or designee will also ensure that the physician's diet orders are being followed as prescribed.

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On 11/1/23 at 11:11 A.M., Resident B's record was reviewed. Diagnoses included dementia with behavior disturbance.

A Service Plan, dated 5/8/23, indicated the resident would be provided a mechanical soft diet with ground meat. Staff were to remind her to go to meals and provide standby/cues for eating assistance.

A physician order, dated 12/25/22, was for a general diet with ground meat texture related to increased difficulty swallowing.

A Grievance form, dated 10/16/23, indicated family was concerned about the consistency of the resident's meals. Staff were to be monitoring all meals for food consistency.

A Grievance form, dated 10/23/23, indicated family was concerned with ground chicken served that hadn't been ground up enough. Family reported the top of the chicken was ground but below that was chopped meat. The cook was interviewed who explained the chicken had been ground up. Parts may have stuck together but were easily separated with a fork.

During a confidential interview, Employee 2 indicated the resident's meat was not always

The Astral at Auburn's contracted dietitian will be providing an Inservice to Dining Service Director, designee, and cooks on dietary requirements, therapeutic diets and resident requests. The in-service has been completed on 11/13/2023.

The Dining Service Director or designee will provide daily meal audits for the next 30 days to ensure dietary requirements, therapeutic diets, resident requests, and physician ordered diets are being followed.

Licensed nurses and care associates will be in-serviced by the Resident Services Director or designee on assisting residents at mealtime per their service plan and ensuring residents receive physician ordered diets by .

The Resident Services Director or designee will audit meal service daily for 30 days to ensure residents receive assistance per their service plan and supplements per physician order.

ground up as ordered.

On 11/1/23 at 12:03 P.M., Resident B's main entree was observed prior to being given to the resident. The plate was covered with a white thick gravy over what appeared to be chunks of meat approximately 1 inch thick. The Dietary Manager (DM) removed the plastic wrap from the plate and with a fork, separated the chunks which fell apart and were finely ground meat. The DM indicated the meat was moistened with broth and gravy which may cause the meat to be sticky and form clumps. The clumps could be picked up with the fork so the ground meat needed to be separated with a fork prior to the resident eating.

2. On 11/1/23 at 12:20 P.M., Resident F was observed in the memory care unit dining room. On his plate, were clumps of a breaded meat patty stuck together and covered with a white thick gravy. He was observed to eat a third of the meat and was coughing as he swallowed the food. He got up from the table leaving most of his lunch on the plate.

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Daily meal service audits will be reviewed and trended in the community's Quality Assurance meeting. Areas of concern will be addressed timely.

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into the lungs instead of being swallowed) which resulted in hospitalization 10/4-10/6/23.

A Service Plan, last reviewed on 7/11/23, indicated the resident would maintain appropriate weight and nutritional status. Staff were to provide a general diet with regular texture and liquids thin in consistency. Staff were to remind him to go to meals where he was independent with eating and drinking. Staff were to encourage fluid and food consumption.

A Nurse Practitioner (NP) progress note, dated 10/12/23 at 12:47 p.m., indicated the resident had been taken to the hospital for acute respiratory distress and was treated for aspiration pneumonia. Speech therapy performed an evaluation and placed the resident on a regular diet with ground meat.

On 11/1/23 at 4:10 P.M., the DM was interviewed. She indicated Resident F was provided with a regular diet with ground meat. His breaded meat patty, observed to be in clumps on his plate, may have stuck together due to the broth and gravy added to keep it moist.

On 11/1/23 at 4:03 P.M., the Administrator provided a current facility policy, titled "Therapeutic Diet Offerings"

which stated: "Each community should offer residents a regular or therapeutic diet, as ordered by their physician...Each community should offer the following diets...Mechanical soft- This diet consists of foods that are moist, soft textured, and easily formed into a bolus. Meats and other select foods may be ground or minced into small pieces no larger than 1/4 inch. All foods should be easy to chew...."

This citation relates to Complaint IN00420396.

Based on observation, interview and record review, the facility failed to ensure resident's daily dietary requirements and requests were met for 2 of 3 residents reviewed (Resident B and Resident F).

Findings include:

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easily separated with a fork.

During a confidential interview, Employee 2 indicated the resident's meat was not always ground up as ordered.

On 11/1/23 at 12:03 P.M., Resident B's main entree was observed prior to being given to the resident. The plate was covered with a white thick gravy over what appeared to be chunks of meat approximately 1 inch thick. The Dietary Manager (DM) removed the plastic wrap from the plate and with a fork, separated the chunks which fell apart and were finely ground meat. The DM indicated the meat was moistened with broth and gravy which may cause the meat to be sticky and form clumps. The clumps could be picked up with the fork so the ground meat needed to be separated with a fork prior to the resident eating.

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Resident F's record was reviewed. Diagnoses included Alzheimer's disease and aspiration pneumonia (occurs when food or liquid is breathed into the lungs instead of being swallowed) which resulted in hospitalization 10/4-10/6/23.

A Service Plan, last reviewed on 7/11/23, indicated the resident would maintain appropriate weight and nutritional status. Staff were to provide a general diet with regular texture and liquids thin in consistency. Staff were to remind him to go to meals where he was independent with eating and drinking. Staff were to encourage fluid and food consumption.

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This citation relates to Complaint IN00420396.

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
SIGNATURE

TITLE

(X6) DATE