STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155666	A. BUILDING 00 B. WING	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUBURN VILLAGE	1751 WESLEY ROAD AUBURN, IN 46706

(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
F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00362130, IN00362118, and IN00362120. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00362118- Substantiated with no deficiencies cited. Complaint IN00362120- Substantiated Federal/State deficiencies related to the allegations are cited at F684, F800. Complaint IN00362130- Substantiated. Federal/State deficiencies related to the allegations are cited at F800, F880, and F886. Survey dates: September 15 and 16, 2021 Facility number: 000307 Provider number: 155666 AIM number: 100285660 Census Bed Type: SNF/NF: 68 Total: 68 Census Payor Type: Medicare: 14 Medicaid: 38 Other: 16 Total: 68 These deficiencies/deficiency reflect/reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 17, 2021	F 0000	**This Plan of Correction (POC) is our proof our compliance with ISDH guidelines and is not an admission of alleged incorrect practices. Auburn Village respectfully requests a bench review resulting in a paper compliance finding for this survey event due to the low scope of severity and low number of citations.**	

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

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to follow physican orders regarding administration of medications for 1 of 5 residents reviewed. (Resident D) Findings include: Resident D was interviewed on 9/15/21 at 10:50 A.M. Resident D indicated medication errors occur frequently when the facility does not have medication. Resident D indicated from 9/10/21-9/13/21 he received wrong dosages of Melatonin (sleep aid). He takes (2) 3mg tablets but was given (1) 5mg tablet. Resident D indicated the QMA on shift told him the facility was supplementing from another resident's supply. Employee 1 was interviewed on 9/15/21 at 2:48 P.M. Employee 1 indicated there are 3 ways to reorder medication: through the computer, to fax or to call. A record review was completed for Resident D on 9/15/21 at 3:40 P.M. The most recent MDS (Minimum Data Set assessment) completed indicated Resident D's BIMS (Brief Interview for Mental Status) score was 15 of 15. This indicated Resident D was alert, oriented and able to answer	F 0684	**This Plan of Correction (POC) is our proof our compliance with ISDH guidelines and is not an admission of alleged incorrect practices. Auburn Village respectfully requests a bench review resulting in a paper compliance finding for this survey event due to the low scope of severity and low number of citations.** F684: **Quality of care: Medication Administration** Compliance with Medication Administration and Reordering of Medication The following plan of correction constitutes the facility allegation of compliance such that all alleged deficiencies cited have been and will be corrected by the date indicated. The statement made on the plan of correction are not an admission to and does not constitute an agreement with alleged deficiencies herein. We respectfully submit that these	09/27/2021

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	questions appropriately. A physician's order, dated 4/9/21, indicated to give Melatonin (2) 3mg tablets at bedtime. The Medication Administration Record (MAR) indicated Melatonin was given as ordered on 9/10/21 - 9/13/21. An order history form for Resident D, dated 5/31/21-9/10/21 was provided by the Assitant Director of Nurisng (ADON) on 9/16/21 at 1:26 P.M. The form indicated Melatonin 60 (3mg) tablets for a 30 day supply were ordered on 7/7/21, 8/3/21 and 9/10/21. There are 26 days between 7/7/21 and 8/3/21. There are 38 days between 8/3/21 and 9/10/21. 4 days of medication would not have been available if given as ordered. The Emergency Drug Kit (EDK) history form, dated 8/13/21- 9/15/21 was provided by the Admissions Director on 9/16/21 at 3:45 P.M. The form indicatded no doses of Melatonin were taken out for Resident D. This Federal citation is related to Complaint IN00362120. 3.1-37 (a)		deficiencies do not exist. To remain in compliance with all state and federal regulation, the facility has taken or will take the actions set forth in the facility plan of correction. **Corrective action plan for F684** Proper training and in-service have been given to all licensed staff to follow procedure on how to order medication through pharmacy before medication is low inventory, reading and dispensing correct dose of medication per physician order. **How were others in the facility affected:** All residents have the potential to be affected by the alleged deficient practice **How the facility will monitor system:** The Director of Nursing (DON) or designee will conduct audits to ensure that medication is being dispensed according to the physician order. These audits wil be completed 4 times weekly for 4 weeks and then monthly for an additional 5 months. Results of these audits will be shared with the IDT during monthly Quality Assurance Meetings. Negative results will add another month to the audit until 100% compliance is achieved for six months total. **Completion Date: September 27 2021/ongoing**	

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F 0800 SS=E Bldg. 00	483.60 Provided Diet Meets Needs of Each Resident §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Based on observation, record review and interview, the facility failed to accommodate dietary preferences for 5 of 5 resident reviewed. (Resident: A, Resident C, Resident D, Resident H, and Resident I) Findings include: 1. Resident A was interviewed on 9/15/21 at 9:24A.M. Resident A indicated she was on a strict renal diet and unable to eat many items that are on the menu. Resident A also indicated she rarely knows what will be served to her until it is brought to her room. 2. Resident C was interviewed on 9/15/21 at 9:53 AM. He indicated when he orders meals from the kitchen, the food is never available or correct. 3. Resident H was interviewed on 9/15/21 at 12:02 PM, with her daughter present. Resident H indicated many times she will receives fish and rice. An observation was made on 9/15/21 at 12:02 PM of Resident H's meal ticket which indicated resident does not like rice or fish. 4. Resident D was interviewed on 9/15/21 at 10:50 A.M. Resident D indicated he does not received what is ordered. He indicated he does not know what he will recieve until it is served. He	F 0800	**Auburn Village respectfully requests a bench review resulting in a paper compliance finding for this survey event due to the low scope of severity and low number of citations. Auburn Village respectfully requests and IDR for this deficiency. Auburn Village would like to dispute the scope and severity of this citation.** **F800 Provided diet meets needs of each resident** The following plan of correction constitutes the facility allegation of compliance such that all alleged deficiencies cited have been and will be corrected by the date indicated. The statement made on the plan of correction are not an admission to and does not constitute an agreement with alleged deficiencies herein. We respectfully submit that these deficiencies do not exist. To remain in compliance with all state and federal regulation, the facility	09/27/2021

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	requested 3 pieces of swiss cheese and 3 pieces of ham for lunch on 9/15/21. He indicated there were 34 times he recceived something different than what had been requested. He presented 34 meal tickets, some signed by CNAs, that indicated the meal he had ordered and the different meal he had received. An observation was made on 9/15/21 at 1 PM. Resident D's meal tray included: 2 pieces of swiss cheese and 3 slices of ham. Resident D's record was reviewed on 9/15/21 at 2:16 P.M. Resident D's care plan, dated 8/6/21, indicated Resident D was at nutritional risk related to morbid obesity with low activity, excessive caloric intake, lymphemdema bilat leg, and diabeties. Resident D chose his own menu and had been educated on consuming a well rounded diet. Resident would refuse meals and would consume food from outside of facility. 5. An observation on 9/15/21 at 11:20 AM in the kitchen area indicated the menu for the day was pot roast, green beans, veggies, garlic toast and frosted cake. Resident I's meal ticket indicated she preferred no gravy. The Dietary Service Manager (DSM) placed the plate of pot roast with gravy on the resident's tray. Employee 9 started to put the tray in the transportation cart. The Surveyor asked Employee 9 if the plated meal followed the diet card. The DSM then replated the resident's food without gravy. The DSM was interviewed on 9/15/21 at 10:42 A.M. The DSM indicated menus are given to residents on Fridays for the following week so the residents are aware of what they will be getting for each meal. The DSM indicated he had spoken with Resident A, who requesteed to have broth,		has taken or will take the actions set forth in the facility plan of correction. **Corrective action plan for F800** Residents A, C, H and D had no adverse effects from the alleged deficient practice. **Procedures to identify other residents having the potential to be affected by the same alleged deficient practice:** All other residents have the potential to be affected by the alleged deficient practice **How the facility will monitor the systems put in place:** RD and or designee reeducated the dietary staff on the facility policy regarding food preferences and closely monitoring, reading and reviewing meal tickets and menus. Dietary manager and/or designee will interview residents on their likes and dislikes. Dietary Manager and/or designee will conduct weekly audits to monitor for compliance to ensure resident received food based on likes and dislikes	

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	Monday thru Friday, for lunch. The Director of Nursing (DON) and DSM were interviewed on 9/15/21 at 1:45 P.M. The DON and DSM indicated they were not able to accommodate all of Resident D's requests. A policy, titled "Food and Nutrition Services Therapeutic Diet Client's Right To Choose" was provided by the Admission Director on 9/16/21 at 1 PM. The policy indicated client's rights to be served food they chose and prefer will be honored. This Federal citation is related to Complaint IN00362120 and Complaint IN00362130. 3.1-20(a)		Administrator and/or designee will conduct random audits to monitor compliance. . Results of these audits will be shared with the IDT during monthly Quality Assurance Meetings. Negative results will add another month to the audit until 100% compliance is achieved for six **Completion date**: September 27, and ongoing	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers,			

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	visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the			

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	facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on interview and record review the facility failed to screen visitors and staff on weekends to prevent COVID-19 for 101 of 144 screening forms reviewed. Findings include: Employee 1 was interviewed on 9/15/21 at 2:53 PM. Employee 1 indicated on the weekends there was no receptionist scheduled, therefore all visitors and staff coming through the front door screened themselves. Employee 7 was interviewed on 9/16/21 at 1:07 PM. Employee 7 indicated when she comes to work on the weekends she screens herself. An observation was made on 9/15/21 at 3 PM, a sign posted at the front desk indicated: Visitors after 8 PM will need to check themselves in. Resident D was interviewed on 9/15/21 at 9:03 AM. Resident D indicated when his friend came to visit on the weekend she was not screened. Employee 8 was interviewed on 9/15/21 at 2:42 PM. Employee 8 indicated there was not a weekend receptionist and no one was present to ensure screenings were completed. Employee 8	F 0880	F880: **Infection Prevention and Control Screening for Covid-19** Compliance with Screening Personnel and visitors for Covid-19 The following plan of correction constitutes the facility allegation of compliance such that all alleged deficiencies cited have been and will be corrected by the date indicated. The statement made on the plan of correction are not an admission to and does not constitute an agreement with alleged deficiencies herein. We respectfully submit that these deficiencies do not exist. To remain in compliance with all state and federal regulation, the facility has taken or will take the actions set forth in the facility plan of correction. **Corrective action plan for F880** The facility will have staff screen all visitors and personnel entering the facility. All staff received training on proper Covid-19 screening process using the screening tool provided by the	09/22/2021

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	also indicated she would pre-fill her name as screener on forms for during the week. Some of those forms had appeared on the weekends when she was not working. Completed Screening forms dated 9/4/21, 9/5/21, 9/11/21 and 9/12/21, were provided by the Admissions Director on 9/15/21 at 11:30 PM. There were a total of 144 forms reviewed. The forms indicated the following: 9/4/21: 8 visitors/staff screened themselves and 42 forms were marked with Employee 8's name. 9/5/21: 29 visitors/staff screened themselves and 13 forms were marked with Employee 8's name. 9/11/21: 33 visitors/staff screened themselves and 10 forms were marked with the Employee 8's name. 9/12/21: 31 visitors/staff screened themselves and 1 form was marked with Employee 8's name. A policy, titled "Core Principles of COVID-19 Infection Prevention," was provided by the Director of Nursing on 9/16/21 at 1 PM. The policy indicated screening would be completed on all who enter the facility for signs and symptoms of COVID-19 and denial of entry of those with signs or symptoms. The Director of Nursing (DON) was interviewed on 9/16/21 at 1:23 PM. The DON indicated the facility follows Indiana Department of Health guidance regarding screening. This Federal citation is related to complaints: IN00362130. 3.1-18(b)		facility. All staff will be asked appropriate question via screening form. **How were others in the facility affected:** Everyone entering the facility has the potential to be affected by the alleged deficient practice. **How the facility will monitor system:** The Administrator/DON or designee will reeducate all staff on process and procedure for screening personnel and visitors before entering the facility immediately as of this date and ongoing. The Designee will ensure all forms are completed. Audits will be completed 4 times weekly for 4 weeks and then monthly for an additional 5 months. Results of these audits will be shared with the IDT during monthly Quality Assurance Meetings. Negative results will add another month to the audit until 100% compliance is achieved for six months total. **Completion Date: September 22, 2021/ ongoing**	
F 0886 SS=E	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff			

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Bldg. 00	§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and			

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	(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.			
	Based on interview and record review the facility failed to follow testing guidance in response to the county positivity rate to prevent COVID-19 for 6 of 6 employees reviewed (Employee 1, Employee 2, Employee 3, Employee 4, Employee 5, and Employee 6). Findings include: A list of unvaccinated staff was provided by the Admissions Director on 9/15/21 at 10:51 AM. The list indicated the following employees were unvaccinated: Employee 2, Employee 3, Employee	F 0886	F886: **COVID-19 Testing – Residents & Staff** Compliance with testing residents and Staff The following plan of correction constitutes the facility allegation of compliance such that all alleged deficiencies cited have been and will be corrected by the date indicated. The statement made on the plan of correction are not an admission to and does not	09/22/2021

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	4, Employee 5 and Employee 6. A testing log was provided by the Admission Director on 9/15/21 at 11:30 AM. The testing log indicated from 8/4/21- 9/8/21: Employee 2, Employee 3, Employee 4, Employee 5, and Employee 6 were tested on 8/4/21, 8/11/21, 8/18/21, 8/25/21, 9/1/21, 9/8/21. A list of positivity rates dated July 2021 to present for the county where the facility was located was requested from the Admissions Director on 9/15/21 at 1 PM and 3 PM. Nothing was received. Employee 1 was interviewed on 9/15/21 at 2:53 PM. Employee 1 indicated she was unvaccinated but had only tested for COVID weekly. An observation on 9/15/21 at 3 PM, of a sign posted at the front desk indicated unvaccinated staff were to get tested weekly. "Indiana COVID-19 Dashboard and Map" (2021) was retrieved on 9/15/21 from the Indiana Coronavirus website. The website indicated for Dekalb county the positivity rate was as follows for weeks: 8/2/21: 14.6%; 8/9/21: 17%; 8/16/21: 10.9%; 8/23/21: 11.9%; 8/30/21: 16%; 9/6/21: 12.8%. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed on 9/16/21 at 1:23 PM. The DON indicated staff should have been tested 2x a week according to positivity rate at the time. A policy, dated 9/2021, was provided by the DON on 9/16/21 at 1 PM. The policy indicated if the positivity rate is above 10%, unvaccinated staff should be tested 2x a week.		constitute an agreement with alleged deficiencies herein. We respectfully submit that these deficiencies do not exist. To remain in compliance with all state and federal regulation, the facility has taken or will take the actions set forth in the facility plan of correction. **Corrective action plan for F886** Facility put in place testing plan for unvaccinated staff to be tested based on the county positivity rate. All staff will be reeducated on the procedure of being tested according to guidelines **How were others in the facility affected:** Those entering the facility have the potential to be affected by the alleged deficient practice **How the facility will monitor system:** The Administrator/Don or designee will ensure testing is occurring according to guidelines. This will occur 2 times a week ongoing based on county positivity rate. **Completion Date: September 22, 2021/ ongoing**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155666	A. BUILDING 00 B. WING	09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUBURN VILLAGE	1751 WESLEY ROAD AUBURN, IN 46706

(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
	This Federal citation is related to complaints: IN00362130. 3.1-18(b)			