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	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUBURN SENIOR LIVING, LLC	1675 W SEVENTH STREET AUBURN, IN 46706

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 16 and 17, 2024 Facility number: 014775 Residential Census: 81 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 21, 2024.	R 0000		
R 0117 Bldg. 00	410 IAC 16.2-5-1.4(b) Personnel - Deficiency (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Grace Faurote	Executive Director	05/31/2024

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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	every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview, and record review, the facility failed to ensure staff certified in cardiopulmonary resuscitation CPR) and first aid were present for 7 of 21 shifts reviewed. 81 residents resided in the facility. Findings include: During a record review conducted on 5/17/24, 11:20 AM, staffing records from the period of 5/10/24 to 5/16/24 indicated the following: On 5/10/24, no first aide certified staff member was present between 10:00 PM and 6:00 AM. On 5/11/24, no first aide certified staff member was present between 2:00 PM and 10:00 PM. On 5/12/24, no CPR or first aide certified staff member was present between 10:00 PM and 6:00 AM. On 5/13/24, no first aide certified staff member was present between 10:00 PM and 6:00 AM. On 5/14/24, no CPR or first aide certified staff member was present between 10:00 PM and 6:00 AM. On 5/15/23, no first aide certified staff member was present between 10:00 PM and 6:00 AM. On 5/16/23, no first aide certified staff member was present between 10:00 PM and 6:00 AM. During an interview on 5/17/24 at 12:15 PM the Executive Director indicated she had provided all available CPR and first aide certification records. She also indicated a CPR and first aide certified staff member should have been present in the facility at all times. A current facility policy titled Cardiopulmonary	R 0117	It is the practice of Auburn Senior Living, LLC to ensure a minimum of one awake staff personnel, with current cardiopulmonary resuscitation (CPR) and first aid certificate. 1. No residents were found to be affected by this deficient practice. 2. All residents residing in the community had the potential to be affected by this same deficient practice. 3. To ensure that the deficient practice does not recur an all-staff certification compliance audit will be completed. The Resident Service Director (RSD) and scheduling designees will be in-serviced on the state law and importance of ensuring certified staff are present. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the RSD/Designee will audit staffing ensuring a minimum of one certified CPR/ first aid personnel is onsite. This audit will be completed daily for 2 weeks and then weekly for 5 months. Audit results will be reviewed/shared with Executive Director (ED) on a monthly basis for 6 months. See attachment A. 5. All systematic changes will be completed by 7/17/24.	07/17/2024

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	Resuscitation, dated 2/29/24, provided by the Executive Director on 5/17/24 at 11:15 AM indicated the facility should have a CPR and first aide certified staff member on duty at all times.			
R 0118 Bldg. 00	410 IAC 16.2-5-1.4(c) Personnel - Deficiency (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record review the facility failed to ensure certification was maintained for 1 of 45 employee certifications and licenses reviewed {Home Health Aide (HHA) 4}. 50 residents resided in the assisted living unit. Findings include: During a record review beginning 5/17/24 at 11:40 AM, HHA 4 did not have a current certification on file at the facility. A Demographic Information form presented by the Executive Director (ED) on 5/17/24 at 12:20 PM indicated HHA 4's certification expired on 5/7/24. A review of nursing department schedules from 5/10/24 to 5/16/24 indicated HHA 4 was on duty on the assisted living unit on 5/10/24, 5/13/24, and 5/14/24. In an interview on 5/17/24 at 12:13 PM, The ED indicated she was unaware of the expired certification. She indicated an expired	R 0118	It is the practice of Auburn Senior Living, LLC to ensure that employees certifications and licensing statuses are verified and up to date. 1. No residents were found to be affected by this deficient practice. 2. All residents residing in the community had the potential to be affected by this same deficient practice. 3. To ensure that the deficient practice does not recur an all-staff certification/licensing compliance audit will be completed. The Resident Service Director (RSD) and Human Resources Director (HRD) will be in-serviced on the regulation and importance of ensuring certifications and licensing are verified and up to date. 4. To monitor the corrective	07/17/2024

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	certification would normally be identified on an audit and she was unaware of why it was not caught. She indicated all employees providing more than limited assistance must maintain a current certification. A current policy titled Background Screening and Annual Verification, dated 5/1/23 provided by the ED on 5/17/24 at 12:58 PM indicated the community must verify the status of any license or certification.		actions and ensure the deficient practice will not recur, the RSD/HRD/Designee will audit staffing ensuring that all staff certifications and licensing are verified and up to date. This audit will be completed on a monthly basis for 6 months. Audit results will be reviewed/shared with Executive Director (ED) on a monthly basis. 5. All systematic changes will be completed by 7/17/2024.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview, and record review the facility failed to ensure conditions were maintained to prevent food contamination in the kitchen. 81 of 81 residents residing in the facility consumed food prepared in the kitchen. Findings include: 1. In an interview during an observation of the kitchen on 5/16/24 at 9:16 AM, a container of cookies and cream ice cream and a container of peach ice cream were observed in the walk-in freezer, unsealed with a portion of their contents removed. An open date and expiration date were not found on either package. A tray of individual pizzas dated 3/15 were covered loosely with plastic wrap. In the walk-in refrigerator, an undated container of gravy was observed on a shelf. A container of thawed chicken in a cloudy	R 0273	It is the practice of Auburn Senior Living, LLC to ensure all food preparation and serving areas (excluding areas in residents' units) are maintained in accordance with state and local sanitation and safe food handling standards. 1. No residents were found to be affected by this deficient practice. 2. All residents residing in the community had the potential to be affected by this same deficient practice. 3. To ensure that this deficient practice does not recur the Dining Service Director/Designee will audit food storage ensuring all food is properly stored and	06/10/2024

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	pink liquid, dated 5/6/24, was observed on a bottom shelf. In the reach in freezer, unlabeled, unsealed, open bags containing chicken strips, breaded fish portions, and french fries were observed. The Dining Services Director (DSD) indicated items should be tightly sealed and all opened items should be labeled and dated. A current policy titled Food Storage, dated 10/25/22 provided by the Executive Director on 5/16/24 at 3:05 PM indicated if a product was removed from its original packaging, it should be tightly wrapped, placed in a sealable plastic bag or container with a tight-fitting lid, labeled and dated with an opened date. 2. During an observation on 5/16/24 at 9:19 AM, the DSD obtained a broom and swept some white particles into a dustpan. She went immediately over to an ice cream freezer and began picking up ice cream containers, bumping open and replacing lids on the containers, while looking for the interior thermometer. No hand hygiene had been performed between tasks. After finishing tasks in the ice cream cooler, the DSD washed her hands in the hand sink. She scrubbed her hands for 10 seconds. When she finished washing her hands, Cook 2 washed her hands for 13 seconds. During an observation and interview on 5/16/24 at 9:46 AM, Cook 3 began the puree process, scratched her left cheek and nose, then reached for the robocoup (machine used to puree food). After being prompted, she washed her hands for 12 seconds. The DSD indicated Cook 3 should have washed her hands after touching her face and hands should be scrubbed for at least 20 seconds. A current policy titled Handwashing for Food		labeled. This audit will be completed daily for 2 weeks and then weekly for 5 months. Audit results will be reviewed/shared with Executive Director (ED) on a monthly basis for 6 months. See attachment B. Facility has switched to pasteurized eggs as of May 28th, 2024. 4. The Dining Service Director/ Designee will in-service the dining service associates on the following topics: 1.Proper Food Storage 2. Labeling and Dating food products 3. Hand Washing 4. Egg Preparation, Cooking, And Storage 5. All systematic changes and in-services will be completed and implemented by June 10th, 2024.	

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	Safety, undated, provided by the Executive Director on 5/16/24 at 3:05 PM indicated hands should be washed before, during and after meal preparation and after touching one's nose. The policy indicated hands should be scrubbed for at least 20 seconds. 3. During an observation and interview on 5/16/24 at 9:16 AM, fresh, uncooked eggs were observed in a box in the walk-in cooler and in a tray in the reach in cooler in the kitchen. The DSD indicated the eggs were unpasteurized. She indicated the unpasteurized eggs were used in recipes and to serve over-easy (undercooked) eggs for breakfast when requested. She indicated there had been no residents with gastrointestinal illnesses recently. A current policy dated 10/25/22 provided by the Executive Director on 5/16/24 at 3:05 PM indicated unpasteurized eggs shouldn't be used in preparation of uncooked ready to eat foods and pasteurized eggs could be cooked and served to individual resident or guest preference.			
R 0328 Bldg. 00	410 IAC 16.2-5-7.1(c)(1-3) Activities Programs - Noncompliance (c) An activities director shall be designated and must be one (1) of the following: (1) A recreation therapist. (2) An occupational therapist or a certified occupational therapy assistant. (3) An individual who has satisfactorily completed or will complete within one (1) year an activities director course approved by the division. Based on interview and record review, the facility failed to ensure the Activities Director had completed an approved Activities Director course within 1 year of hire. 81 residents lived in the facility.	R 0328	It is the practice of Auburn Senior Living, LLC to ensure that the Activity Director has completed an approved Activity Director course. 1. No residents were found to be	07/17/2024

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	Findings include: A review of facility employee files indicated the Activity Director had not completed an approved Activities Director course. In an interview on 5/17/24 at 12:28 PM the Executive Director (ED) indicated the Activities Director had been hired as the Activities Director on 3/28/23. The ED indicated the Activities Director course should have been completed with 1 year of being hired. She indicated the facility did not have a policy related to Activities Director educational requirements.		affected by this deficient practice. 2. All residents residing in the community had the potential to be affected by this same deficient practice. 3. To ensure that this deficient practice does not recur the Activity Director will be registered in to an approved activity director course. This program will be reviewed and approved by the Executive Director (ED). 4. The Activity Director will be in-serviced on the importance of this program and completion of the approved activity director program. Until completion of course, the Activity Director will continue to receive consultation with Corporate Director of Life Enrichment and Memory Support who holds a Therapeutic Recreation Specialist Certification. 5. All systematic changes will be completed by 7/17/2024 .	
R 0357 Bldg. 00	410 IAC 16.2-5-8.1(j)(1-3) Clinical Records - Noncompliance (j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on interview and record review, the facility failed to ensure complete and accurate	R 0357	It is the practice of Auburn Senior Living, LLC to ensure that all	05/29/2024

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	documentation related to the resident's condition, vital signs preceding death, the release of resident remains, the release of personal belongings and the disposition of medications for 1 of 1 record reviewed (Resident 7). Findings include: Resident 7's record was reviewed on 5/17/24 at 9:45 AM. Diagnoses included dementia and chronic kidney disease. A progress note, dated 5/14/24 at 10:03 AM, indicated Resident 7's temperature was 96.4. The note indicated Resident 7 did not have a pulse and was not breathing. The note indicated the hospice provider, the family, the Executive Director (ED) and the Assistant Director of Nursing had been notified. A progress note dated 5/14/24 at 11:15 AM indicated Resident 7's respirations had ceased. The note was the last entry in Resident 7's record. Resident 7's record did not indicate the date and time of the release of their remains, the date and time of the release of their personal belongings, or the disposition of their medications. Resident 7's Weights and Vitals Summary dated 5/1/24 through 5/31/24 indicated the resident's vital signs had been assessed on 5/1/24 and 5/10/24. No further documentation of vital signs were available for review. In an interview on 5/17/24 at 10:15 AM the Director of Nursing (DON) indicated the facility staff should have completed a full assessment of Resident 7 preceding death. The DON indicated the facility staff should have documented the release of Resident 7's remains.		correct and accurate documentation should be completed upon the death of a resident. 1. Resident 7, has deceased and chart has been closed. 2. All residents residing in the community had the potential to be affected by this same deficient practice. 3. To ensure that the deficient practice does not recur Resident Service Director/ Designee will complete a review of residents' chart upon death and review that the documentation includes: (1) Notification of the physician, family, responsible person, legal representative, and hospice (if applicable) is completed. (2) The disposition of the body, personal possessions, and medications . (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Resident Service Director/ Designee will complete this on all deaths in community for 6 months. 4. To monitor the corrective actions and ensure the deficient practice will not recur, the RSD/Designee will in-service the nursing associates on the importance of correct and accurate documentation upon the death of a resident. In-service will	

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	A current facility policy dated 3/1/21 provided by the ED on 5/17/24 at 10:32 AM indicated the facility should document the incident and return medications to the pharmacy for destruction.		be completed on 5/29/2024. 5. All systematic changes will be completed by 5/29/2024.	