STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155303	A. BUILDING 00 B. WING	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SERENITY SPRING SENIOR LIVING AT JASONVILLE	800 E OHIO ST JASONVILLE, IN 47438

(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 a Recertification and State Licensure Survey. Survey dates: February 4, 5, 6, 7 and 10, 2025 Facility number: 000200 Provider number: 155303 AIM number: 100367980 Census Bed Type: SNF/NF: 36 Total: 36 Census Payor Type: Medicare: 3 Medicaid: 22 Other: 11 Total: 36 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed February 13, 2025.	F 0000	*February 24, 2024* *To : Long Term Care Director* *Attention Brenda Buroker* *Indiana State Department of Health* *2 North Meridian Street,* *Indianapolis, IN 46204* *Re: Serenity Spring Senior Living at Jasonville* *CCN/Provider Number: 155303* *AIM Number: 100367980* *Facility ID: 000200* *This letter comes to you as a request for paper compliance to the facility's Recertification and State Licensure Survey dated February 4th through February 10th 2025.* *The facility received 3 deficiencies which were low scope and severity in nature* *The facility feels it has corrected the deficiencies and submits to the department the following proof of corrections.* *Please see the uploaded corrections.* *Sincerely,* /i>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah E Davis	LHFA	02/24/2025

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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			Deborah E Davis, Health Facility Administrator *812-665-2226*	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) assessment for 2 of 13 residents reviewed for accuracy of the MDS assessments. (Resident 4, Resident 21) Findings include: 1. On 2/10/25 at 9:44 a.m., Resident 4's clinical record was reviewed. The diagnoses included, but were not limited to, UTI (urinary tract infection) and congested heart failure. Resident 4's February 2025 Physician Orders indicated Macrobid (antibiotic) 50 milligrams (mg) by mouth at bedtime for UTI with a start date of 8/28/24. The Medication Administration Record (MAR), dated 11/28/24 through 12/4/24, indicated Macrobid 50 mg was administered at bedtime for UTI prevention. The quarterly MDS (Minimum Data Set) assessment, dated 12/4/24, lacked documentation of antibiotic use in the last seven days.	F 0641	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. **F641 Accuracy of Assessments (D)** **Corrective Action: The MDS assessment will accurately**	02/24/2025

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	During an interview on 2/10/25 at 11:45 a.m., the MDS nurse indicated antibiotic use was not coded on the quarterly MDS assessment, dated 12/4/24, and it should have been. 2. On 2/5/25 at 2:56 p.m., Resident 21's clinical record was reviewed. The diagnoses included, but were not limited to, compression fracture, adult failure to thrive, and urinary tract infection (UTI). A review of the resident medical record indicated, on 11/27/24, the resident returned from the hospital, due to unrelated condition, and an order for Cefdinir oral capsule (antibiotic) was received related to UTI. Review of the emergency room triage note, dated 11/26/24, urine culture results, collected on 11/26/24, and discharge medications, dated 11/27/24, indicated resident was diagnosed with an UTI. A review of the Significant Change MDS assessment, dated 12/12/24, lacked documentation of UTI diagnosis. During an interview with MDS nurse on 2/10/25 at 11:45 a.m., she indicated on the Significant Change MDS assessment, dated 12/12/24, a diagnosis of UTI was not coded and according to RAI (Resident Assessment Instrument) tool criteria it should have been. A review of the RAI User's Manual (v.1.19.1, effective 10/1/24) on 2/10/25 at 11:55 a.m., indicated for diagnosis of UTI, "a look-back period of 30 days for active disease instead of 7 days... physician diagnosis of UTI prior to admission is acceptable. This information may be included in the hospital transfer summary or other paperwork." During an interview with the MDS nurse on		**reflect the resident's status, to include the resident's status in a Significant Change Assessment** Resident 4, Assessment was Modified to include Macrobid that was being given prophylactically on 2/18/25 Resident 21, Assessment was modified to include Dx of ITU on 2/18/25 Please see the attached Validation report from LTC that was received for the above 2 residents Re-education and guidelines for accurate assessment of the resident's status will be given to the MDS Coordinator by the Director of Nursing on 2/20/25 **Potential for others to be affected: Through an immediate audit of those residents who received antibiotic therapy no others were found to be affected** Residents who have the potential to be affected have been reviewed and an audit system set up to correct/prevent omissions on the assessment during the assessment reference period. Please see the attached audits that have been completed thus far. **Systemic Changes that have been put in place:** **Random MDS Audits will be performed to aid in assuring**	

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	2/10/25 at 1:50 p.m., she indicated the facility did not have a MDS assessment coding policy. She indicated the facility followed the RAI manual for coding MDS assessments. 3.1-31(d)		**the accuracy of the MDS/resident assessment** MDS accuracy will be reviewed by the Director of Nursing or her Designee through auditing /reviewing resident assessments during the facility's weekly Risk Assessment Meeting. The Risk Assessment Committee will randomly review 2 residents who have been identified as being in their assessment window, to assist in ensuring the MDS assessment has been accurately completed **Monitoring of Compliance:** **Compliance will be monitored by the Risk Assessment Committee** MDS or designee will set up an audit system to be reviewed and approved by the Risk Assessment Committee. 2 random audits to be completed weekly for 1 month, then 2 random audits will be completed monthly or until the facility is deemed in compliance by the Risk Assessment Committee and reported to the QA Committee. **Date of Completion 2/24/25**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning	F 0695		02/24/2025

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	Based on observation, record review, and interview, the facility failed to provide respiratory care for 1 of 1 residents reviewed for oxygen therapy. Oxygen tubing was not labeled with a date or documented oxygen tubing was changed. (Resident 30). Finding includes: On 2/4/25 at 2:44 p.m., Resident 30 was observed lying in bed with the O2 (Oxygen) nasal cannula (NC) not in nares (nose). There was no date observed on the NC tubing. On 2/6/25 at 9:30 a.m., Resident 30 was observed lying in bed with O2 in place at 2 L (liters) via NC. There was no date observed on the NC tubing. On 2/7/25 at 9:01 a.m., Resident 30 was observed lying in bed with O2 being administered at 2 L via NC. No date was observed on the NC tubing. During an interview on 2/7/25 at 10:50 a.m., LPN 1 indicated there was no date on the oxygen tubing. During an interview on 2/7/25 at 11:04 a.m., the DON indicated that the oxygen tubing was changed every Friday. The DON indicated tubing changes should be documented on the Treatment Administration Record (TAR). On 2/6/25 at 9:31 a.m., Resident 30's clinical record was reviewed. The diagnoses included, but were not limited to, Chronic Obstructive Pulmonary Disease (COPD), respiratory failure with hypoxia (low level of oxygen in the blood), and dementia. The Admission Minimum Data Set (MDS) assessment, dated 1/13/25, indicated oxygen therapy.		Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. **F 695** **Respiratory/Tracheostomy Care and Suctioning (D)** **Corrective Action: The facility will provide respiratory care for residents with oxygen therapy** Resident 30, oxygen tubing was immediately changed labeled with staff initials and dated on 2/10/25 as per facility policy. Order written on 2/10/25 to change 02 tubing and cannula weekly on Fridays and as needed. It is noted that the resident frequently removes labeling and forgets that the labeling should stay in place. This is identified by his resident profile and care plan.	

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	A review of resident's care plan, initiated on 1/7/25, indicated the resident had oxygen therapy. A physician's order, dated 1/7/25, indicated oxygen at 2 LPM (liters per minute) per nasal cannula via O2 concentrator and/or tank continuously. The physician's orders lacked an order to change to oxygen tubing. The clinical record lacked documentation the oxygen tubing had been changed. During an interview on 2/10/25 at 10:17 a.m., the DON indicated an order was placed on 2/10/25 for Resident 30's oxygen tubing to be changed. 3.1-47(a)(6)		**Others having the potential to be affected:** Residents who have oxygen orders have the potential to be affected, However, upon an immediate audit no others were found to be affected and labeling/date changed was present. The facility's policy as to Oxygen Administration, Safety, Mask Types- R/S, LTC, Therapy and Rehab revised date of 2/10/25, identifies the Oxygen tubing to be changed weekly and as needed then labeled with staff initials and dated correctly, Nursing staff were re-educated as to the policy starting on 2/11/25 and was on-going through 2/18/25. **Systemic Changes to Occur:** Systemic change will occur to ensure that residents' oxygen tubing is changed, labeled with initials and dated weekly per facility policy, residents who have orders for oxygen will have oxygen administered per physician orders. The policy Oxygen Administration, Safety, Mask Types- R/S, LTC, Therapy and Rehab will be reviewed by the DON. The DON or designee during random rounding will provide nursing staff with education sessions related to Oxygen administration as to applying and re-applying after any transfers, labeling, changing	

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			weekly and dating policy, if non-compliance is noted. **Monitoring of Systemic Changes:** The Director of Nursing or her designee will conduct audits weekly for 6 weeks, then monthly for 3 months. The audits will be reviewed at the Weekly Risk Meetings and the at Risk Committee will note further issues of non-compliance and further Systemic changes that require any changes. The Director of Nursing or designee will present the audits to the QA Committee during monthly meetings until substantial compliance has been accomplished. Date of Compliance: 2/24/25	
F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, interview, and record review, the facility failed to ensure food was stored in a sanitary manner for 1 of 2 kitchen observations. Expired foods were not discarded and food was not labeled. Findings include: On 2/4/25 at 10:17 a.m., during the initial tour of kitchen with the Dietary Manager (DM), the following was observed: - The refrigerator by the serving line had a pitcher	F 0812	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation	02/24/2025

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	of red liquid. The pitcher lacked a date on it. At that time, the DM removed the pitcher and indicated it should have had a date on it. - The walk-in refrigerator had two cartons of sour cream with an expiration date of 1/31/25. The DM indicated the sour cream was expired and should have been discarded. - The walk-in refrigerator had seven half gallons of buttermilk with an expiration date of 1/31/25. The DM indicated the buttermilk was expired and should have been discarded. The DM indicated staff checked for expired food every day. On 2/10/25 at 1:50 p.m., the Director of Nursing (DON) provided the facility's policy, "Food Receiving and Storage," undated, and indicated it was the policy currently being used by the facility. A review of the policy indicated "1. All foods stored in the refrigerator or freezer are covered, labeled and dated ("use by" date)....7. Refrigerated foods are labeled, dated and monitored so they are used by their "use by" date, frozen, or discarded..." 3.1-21(i)(2) 3.1-21(i)(3)		that the facility is not substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with 7305 of the State Operations Manual. F 812 Food Procurement Store/Prepare/Serve-Sanitary **What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?** **It is noted that no residents were put at risk as the Buttermilk and the sour cream containers were unopened all accounted for and unopened.** Food Safety will be maintained by ensuring food is stored, labeled and prepared in a sanitary manner. Ensure beverages and foods that are in stock are not expired and are labeled with date and products name. Food and beverage expiration dates will be checked upon delivery from the vendor and disposed of immediately if outdated, then re-checked every am and pm before use. **How will you identify other**	

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			residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents who are being served food/beverages from the facility kitchen have the potential to be affected. Beverages and foods are being observed during random times of the day for expiration dates by the Dietary Manager. Dietary staff were re-educated on 2.4.25 and again on 2.19.25 on the proper guidelines to ensure food/beverages are used within their expiration dates and if food or beverages are found to be expired they are immediately discarded. **What Systemic Changes will be put into place?** The Dietary Manager or her Designee will complete a daily checklist to include labeling, dating, and proper storage of food/beverages, and if found expired items will be immediately discarded. The Dietary Manager will immediately report any non-compliance, the identified employee will go through one-on-one training with the Administrator and any further issues of reported non-compliance will result in the start of the	

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			disciplinary process, including termination if deemed necessary. The administrator held a mandatory meeting with dietary staff on 2-19-25, to review the findings of the audit process, their progress thus far, and any suggestions/questions staff wanted to bring forth. Immediate resolutions are being put into place. **How will Systemic Changes be monitored?** The Dietary Manager or her Designee will be responsible for the completion of the sanitation review of the kitchen at random times during and after meal service, any issues will be brought forth to the Administrator for correction These audits will be completed 5 times a week for 3 weeks and then weekly for 3 months. Results of the sanitation audits will be discussed in the facility's monthly Quality Assurance meeting and will be deemed in compliance when corrective actions reach 100 % , if the threshold of 100% has not been reached, the Administrator will re-evaluate and revise the existing POC action plan. Date of compliance: 02/24/2025	