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	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUBURN SENIOR LIVING, LLC	1675 W SEVENTH STREET 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
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: May 8 and 9, 2023 Facility number: 014775 Residential Census: 66 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed May 10, 2023.	R 0000	Please accept this Plan of Correction for the Health Survey ending May 9, 2023, as the Provider's letter of credible allegation of compliance. This Provider respectfully requests consideration for paper compliance in lieu of the revisit survey for this Plan of Correction, with a completion date of 7/9/2023.	
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	05/20/2023

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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	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 in the facility 7 of 21 shifts reviewed. 66 residents currently resided in the facility.. Findings include: During a record review conducted on 5/9/23 at 11:09 AM, staffing records from the period of 5/1/23 to 5/7/23 were reviewed. On 5/1/23, no CPR or first aide certified staff member was present between 2:00 PM and 6:00 PM. On 5/2/23, no CPR or first aide certified staff member was present between 8:00 PM and 10:00 PM. On 5/5/23, no CPR or first aide certified staff member was present between 10:00 PM and 6:00 AM. On 5/6/23, no CPR or first aide certified staff member was present between 2:00 PM and 6:00 PM. On 5/6/23, no CPR or first aide certified staff member was present between 10:00 PM and 6:00 PM. On 5/7/23, no CPR or first aide certified staff member was present between 5:00 PM and 10:00 PM.	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. 1. No residents were found to be affected by this deficient practice. 2. 2. All residents residing in the community had the potential to be affected by this same deficient practice. 3. 3.To ensure that the deficient practice does not recur an all-staff certification compliance audit will be completed. The Resident Service Director (RSD) Scheduling designees will be in-serviced on the state law and importance of ensuring certified staff are present. 4. 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. 5. All systematic changes	07/09/2023

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	On 5/7/23, no CPR or first aide certified staff member was present between 10:00 PM and 6:00 AM. During an interview on 5/9/23 at 12:30 PM the Director of Nursing indicated she had provided all available CPR and first aide certification records. She also indicated a CPR and first aide certified staff member should be present in the facility at all times. During an interview with the Administrator on 5/9/23 at 1:07 PM, she indicated she was unable to provide a facility policy pertaining to CPR and first aide certification.		will be completed by 7/9/23.	
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 maintain a clean kitchen. 66 of 66 residents residing in the facility ate food prepared in the kitchen. Findings include: During a kitchen tour with the Dietary Manager (DM) on 5/8/23 at 9:25 AM, food debris was observed throughout the kitchen. Areas of the floor under counters and in corners were littered with food debris and dust. The floor under the deep fryer was covered with a oily residue. The floor under the deep fryer was littered with onion rings, shoestring potatoes, and unknown food debris.	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. 1. No residents were found to be affected by this deficient practice. 2. 2. All residents residing in the community had the potential to be affected by this same deficient practice. 3. 3. To ensure that the	05/26/2023

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	During an interview on 5/8/23 at 9:30 AM, the Dietary Manager (DM) indicated the kitchen floors were swept at the end of each meal. He indicated the kitchen floors were mopped at the end of each day. He indicated the floor under the deep fryer had been mopped 3 days ago. He indicated the kitchen did not have enough staff over the weekend to mop. He indicated he was unaware of a cleaning schedule. He indicated he had been employed at the facility for 1 week. On 5/8/23 at 11:35 AM, the storage shelves under the food preparation sink were observed to be covered with grey colored and dried food debris (shredded cheese). The wall behind the food preparation sink was covered in grey debris. The floor under the food prep sink was covered with clumps of brown and grey debris. A metal mouse trap was observed on the floor. On 5/8/23 at 11:50 AM, dry storage bin lids were observed to be coated with smudges, fingerprints, and grey debris. The floor surrounding the storage bins was littered with oatmeal and sugar. During an interview on 5/8/23 at 2:10 PM, the DM indicated the kitchen could use a thorough cleaning. He indicated he would post a cleaning schedule as soon as possible. A current policy titled "Cleaning Schedule" provided by the Executive Director (ED) on 5/9/23 at 9:50 AM indicated the dietary department should have implemented a written and posted cleaning schedule. The policy indicated individual tasks should be signed upon competion.		deficient practice does not recur the Dining Service Director will implement a department cleaning schedule that will indicate equipment/department cleaning tasks by position daily. 4. 4. The Dining Service Director/designee will in-service the dining associates on cleaning schedules and the importance of completing daily cleaning tasks. The serving shelves, dry storage bins and floors have been properly cleaned and sanitized as of May 18, 2023. 5. 5. All systematic changes will be completed by May 26, 2023.	