STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155666	A. BUILDING _____ B. WING _____	**07/29/2020**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on observation, interview, and record review, the facility failed to ensure sufficient nursing staff were available to administer medications and treatments timely for 25 of 32 residents who resided on one unit in the facility. Findings include: On 7/27/20 at 11:38 A.M., Resident K, identified by the facility as interviewable, was interviewed. During the interview, he expressed much frustration with the facility's alleged lack of nursing staff. The resident alleged there were never enough nurses to administer medications on time and believed he was not always being given all of his medications when they were administered by agency nurses. Resident K indicated the past weekend, he was to have had a treatment done before 9:00 p.m. but had not been completed until after midnight allegedly due to having only 1 nurse in the facility. On 7/29/20 at 10:50 A.M., Resident K was observed lying in bed. He indicated he had not yet had his treatment completed which was due to be done by 11:00 a.m. so he could get up and go to therapy. He indicated he was told by his CNA (Certified Nurse Assistant) that there was no nurse for the hall he resided on. On 7/29/20 at 10:55 A.M., Staff 2 and Staff 5 were observed standing at the medication cart counting narcotics together. When questioned, Staff 2 indicated she had been the only nurse on the unit since 5:00 a.m. and that the other nurse scheduled, had called in. There were usually 2 nurses assigned to the unit and each one was responsible for a hall. Staff 5, who had been scheduled for and was working another unit, indicated she had been told after completing the med pass on her unit, to come to this unit and help pass medications. Staff 5 indicated she was going to assist Staff 2 with the morning medication pass and then would return to her unit. Staff 2 indicated she had tried to administer medications scheduled before breakfast on both halls but had other critical tasks that had needed to be done and was still trying to pass the remaining medications due on her assigned hall. Review of the daily nursing staff schedule for 7/29/20 indicated on 1st shift, there was present 1 RN (Registered Nurse), 2 LPN's (Licensed Practical Nurse), and 1 QMA. An LPN had called off for 1st shift and there was no other nurse listed as a replacement. Staff interviews indicated the following: On 7-27 at 10:05 A.M.Staff 2 indicated staffing on the units were not equal and that 1 unit had 1 nurse for 7 residents and another unit had 1 nurse for 32 residents. Further, licensed staff were responsible for completing assessments on residents so if a QMA (Qualified Medication Aid) was assigned on a unit with a nurse, the QMA could pass medications but the nurse would be responsible for their own med pass, all of the required assessments, plus the insulin/intramuscular injections the QMA was not licensed to do. Staff 2 indicated because of the Covid precautions, residents were to have a full set of vital signs and assessments done 2 times per shift. Nursing staff worked 12 hour shifts. Staff 2 indicated it took approximately 5 minutes to complete vital signs, assessments and documentation each time completed on a resident. When 1 nurse had 32 residents to complete vital signs and assessments on, it would take approximately 5 out of the 12 scheduled hours just to complete this task. On 7-27-20 at 2:36 P.M. Staff 3 indicated medication pass was difficult throughout the building but could be accomplished on the units if all the nursing staff were present as scheduled. They indicated if the facility were short staffed or if emergencies arose with residents, medications could not be administered timely and as ordered. On 7-28-20 at 11:48 A.M. Staff 4 indicated staffing had been an issue over the last couple of weeks but they had been able to cover all shifts with the allotted staff required to provide care to residents. On 7-29-20 at 10:12 A.M. Staff 6 indicated it was difficult on the rehabilitation unit to finish medication passes timely, especially if there was a call in or a resident became acutely ill. Review of the MAR (Medication Administration Record) for residents who resided on the rehabilitation unit indicated 25 of the 32 residents had not received all of their medications scheduled to be given on 7/29/20 between 6:00 a.m. and 10:00 a.m. On 7/29/20 at 11:32 A.M., the DON (Director of Nursing) was interviewed. During the interview, she indicated she had been made aware of the staffing issue and had assigned a nurse, already assigned to a hall, to assist with passing medications after their med pass was completed. She had not been aware that the nurse had not helped on the rehab. unit nor was she aware that medications had not been administered as ordered. She indicated medications could be administered during a scheduled time period such as 6:00 a.m. - 10:00 a.m. or scheduled at a specific time such as 8:00 a.m. If a medication or treatment were scheduled in a time period such as 6:00 a.m. - 10:00 a.m., the medication must be given between 6:00 a.m. - 10:00 a.m. to be considered timely. If a medication was scheduled for a specific time such as 8:00 a.m., it could be administered 1 hour before or 1 hour after the scheduled time to be considered timely. On 7/29/20 at 2:20 P.M., the Regional Nurse Consultant provided the Facility Assessment for review which indicated to meet the resident's care needs, the facility was to be staffed on 1st shift with 1 RN, 3 LPN's, and 1 QMA. This Federal tag relates to Complaints IN 289, IN 248, and IN 046. 3.1-17(a)

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.