

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155666	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/02/2024
NAME OF PROVIDER OR SUPPLIER  Auburn Village		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37147</b></p> <p>Based on interview and record review, the facility failed to ensure education about and follow public health authority recommendations during investigation of a communicable disease outbreak. This alleged deficient practice affected 1 of 3 residents reviewed (Resident M).and had the potential to affect of 68 residents residing in the facility.</p> <p>Findings include:</p> <p>An anonymous complaint to the Indiana Department of Health (IDOH), dated 6/25/24, indicated Legionella bacteria had been found in water samples collected at the facility and recommendations made to prevent disease were not being followed.</p> <p>Legionnaires' Disease, retrieved from CDC.gov (Centers for Disease Control) on 6/27/24, indicated Legionnaires' disease was a very serious type of pneumonia caused by Legionella bacteria. Legionnaires' disease could cause pneumonia symptoms of cough, muscle aches, fever, shortness of breath, and headache. Legionella bacteria lived in fresh water and man-made settings such as large or complex water systems found in hospitals or nursing homes. Legionella bacteria could grow in these man-made systems if the water was not properly maintained, and could become a health problem when small droplets of water, containing the bacteria, got into the air and people breathed them in. In rare cases, persons could breathe in Legionella bacteria while drinking water and it goes down the wrong pipe into the lungs. In general, Legionnaire's disease was not spread from person to person. Common water sources of Legionella bacteria include water used for showering. When Legionnaires' disease is found, it should be reported to the Local and State Health Departments promptly to allow public health officials to quickly identify and stop potential clusters and outbreaks by linking new cases to previously reported ones. Public Health Authorities are responsible for investigating cases of Legionnaires' disease which typically involves four public health fields: epidemiology, environmental health, laboratory science, and health communication.</p> <p>Centers for Medicare and Medicaid Services (CMS) interpretive guidelines for healthcare-associated Legionella disease indicated: The facility should contact the local/state public health authority if there is a case of healthcare-associated legionellosis or an outbreak of an opportunistic waterborne pathogen causing disease. The facility must follow public health authority recommendations which may include, but is not limited to, remediating the pathogen reservoir and adjusting control measures as necessary.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/27/24 at 11:09 A.M., the Maintenance Director was interviewed about the facility's water management program. He indicated they had a program in place and were currently working with their water management consultant company to flush the water systems due to positive water tests for Legionella bacteria. He indicated there were no positive water tests for the Legionella species which caused disease.</p> <p>On 6/27/24 at 11:15 A.M., the Administrator and Maintenance Director were interviewed. The Administrator indicated they were notified by the Infectious Disease Epidemiology &amp; Prevention Division of IDOH of a resident (Resident M) who tested positive for Legionnaires' disease when hospitalized in March 2024. He indicated the resident had discharged from the facility prior to their notification and the facility had not been notified by the hospital upon her return. He indicated the facility had been working with Epidemiologist's (Public Health workers who investigate patterns and causes of disease and injury) at IDOH and their water management company to find the source of the infection and put corrective measures in place. He indicated water samples, submitted per IDOH instruction, were found with Legionella bacteria but were not the species which caused Legionnaires' disease. He provided lab test results and map of the facility which indicated where samples had been obtained. The facility, in consultation with their water management company, had started flushing the water system 3 times per week, recorded water temperatures, chlorine levels following the water flush to monitor and raised the level of chlorine to effectively remove Legionella bacteria from the water system. He indicated the Epidemiologist at IDOH had made several recommendations, most of which they followed, but hadn't been able to install Point of Use ([NAME]) filters on their shower heads and continued to use the showers per resident's preference. The cost of replacing all the shower heads was costly and their water management consultant believed it was not necessary.</p> <p>On 6/27/24 at 11:52 A.M., Resident M's record was reviewed. Diagnoses included chronic obstructive pulmonary disease, diabetes, and chronic respiratory failure. She had been hospitalized [DATE]-[DATE] for pneumonia due to influenza and 3/18/24-3/27/24 for acute on chronic respiratory failure and pneumonia. Resident M had resided in a room where a positive water sample had been found for Legionella bacteria after discharging home from the facility.</p> <p>On 6/27/24 at 1:54 P.M., the Administrator provided copies of the water testing results and email exchanges between the facility, water management consultant company and Epidemiologists from IDOH as follows:</p> <p>-4/9/24: The facility was notified by IDOH of a Legionella outbreak investigation based on a resident's (Resident M) positive urine test for Legionella and diagnosis of Legionnaires' disease at the facility. The resident had spent 12 days of the 14 day incubation period at the facility which according to the CDC, prompted an outbreak investigation. IDOH requested documents from the facility and gave recommendations for implementation of immediate water precautions which were: remove ice machines from service, use bottled water for drinking, and remove showers from service until point of use filters could be installed. It was recommended the facility increase surveillance of residents and staff for symptoms of Legionnaires' disease.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-4/16/24: An email, detailing a meeting which occurred in the morning with IDOH, local health department and facility staff, had included information shared about Legionella, outbreak response responsibilities of IDOH staff, consideration of notification to resident's and staff or possible drafting of a media statement, and case specific responses detailing Resident M's case. Due to the amount of time the resident spent at the facility, the case was considered, by the CDC, a presumptive healthcare-associated case which implicated the facility. The facility had provided the requested information and immediate water precautions implemented including providing bottled water for drinking, regular flushing per the water management program, cleaning and disinfecting the ice machines, checking their filters and ordering a chlorometer (device to measure amount of chlorine in the water). The facility had increased surveillance for symptomatic individuals and was waiting to implement additional water precautions depending on the water sample results. The facility had contracted with a lab and water samples were to be obtained the following day (4/17/24).</p> <p>-5/9/24: Water samples for Legionella, collected on 4/17/24, resulted in 12 of 35 samples positive for Legionella bacteria.</p> <p>-5/13/24: Lab test results were sent to the facility from the water management consulting company and meeting held between the company and facility to discuss the Legionella investigation testing and IDPH (Indiana Department of Public Health) recommendations. The water company offered their recommendations which were to increase flushing of water at all positive water sample locations for at least 10 minutes per day, at least 3 days per week; measure water temperature after hot water flush; and measure free chlorine after cold water flush for the next 2 weeks and retest. The email indicated if the department of public health changed their recommendations to mandates, the water company would recommend following their guidance.</p> <p>-5/14/24: An email to IDOH indicated the facility would be following recommendations per the consulting water management company. IDOH sent an email, in response, which indicated a meeting was scheduled for 5/21/24 to focus on: Immediate water precaution recommendations, including point-of-use filters, bottled water for drinking, and ice machine use, based on the initial sampling results and what the monitoring period would look like including frequency of sampling, timeline for sampling, quantity and types of samples, etc.</p> <p>-5/29/24: IDOH sent an email to the facility to inquire if the facility had decided on what water precautions to implement, considering the system had tested positive for Legionella; and reminder all Legionella had the potential to cause human illness. The email indicated IDOH recommendations were to install point of use filters onto showerheads currently in use and until [NAME] filters were installed, bottled water should be used for bathing. If the facility decided not to install the [NAME] filters, the bottled water was to be used for bathing and showers not used; Bottled water was to be used for drinking until the end of the response; ice machines removed from service or equipped with [NAME] or in-line filters; and increased surveillance of residents and staff for symptoms consistent with Legionnaires' disease. The email also asked if the facility had been able to conduct system remediation which could include chemical treatment, increased flushing, or replacement of plumbing components. The facility responded and indicated, with direction from their water management team, they had decided to do the following:</p> <ul style="list-style-type: none"> <li>-Increase flushing to 3x/week &amp; test free chlorine on all of those days</li> <li>-Increase respiratory monitoring</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Regenerate water softeners</p> <p>-Ordered point of use filters for ice machines</p> <p>-Retesting to occur once flushing period occurs for 1 month.</p> <p>5/30/24: An email from IDOH indicated CDC recommended showers be restricted and bed baths used instead since the facility was unable to install [NAME] filters onto showerheads. The email provided a link to CDC recommended control measures which stated: Implementing Control Measures-implement immediate control measures to help reduce the risk of ongoing transmission and prevent exposure to systems or devices suspected to have Legionella. Examples of immediate control measures for potable water systems include:</p> <p>-Restricting showers (using sponge baths instead)</p> <p>-Installing point-of-use microbial filters</p> <p>6/19/24: An email sent from the facility to IDOH had chlorine logs attached and recommendations made by the facility water management company for next steps. The facility hadn't identified any other symptomatic residents and the facility had regenerated the water softeners and installed filters on the ice machines. The facility elected not to do the sponge bathing due to resident preferences. The facility had done flushing for 10 minutes hot water followed by 10 minutes cold water, 3 days per week over the past 4 weeks, monitored chlorine levels, drained 2 of 3 hot water heaters, regenerated the water softner and disinfected all affected fixtures. The facility would continue flushing for 2 more weeks, increase draining debris from all 3 hot water tanks and replace 6 affected fixtures that had not improved in chlorine readings.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/1/24 at 1:45 P.M., the Director of Nursing (DON), Administrator, and Infection Preventionist (IP) were interviewed and provided a copy of the facility's infection control investigation. They indicated Resident M had been in a private room and hadn't come out of her room. She had been hospitalized multiple times for pneumonia and was symptomatic with respiratory symptoms when returning from the hospital prior to the incubation period. They had several teams meetings with IDOH, the Administrator, Maintenance Director, Director of Nursing, and water management consultant company and believed they were following recommendations to prevent transmission and exposure to Legionella. The Administrator indicated they had incorporated discussing resident's respiratory risk daily in their morning meetings, educated staff on infection control and respiratory illness (5/5/24), and consulted with the facility's pulmonologist, physician and NP (Nurse Practitioner) who had no concerns with other residents. Staff were to observe high risk residents for respiratory illness as standard practice and notify the physician, NP, resident, family and DON of changes. The DON indicated they had purchased bottled water but it was not being used for bathing or drinking. The Administrator indicated they had spoken with residents who had indicated they were not willing to have bed baths instead of showering. There was no documentation provided to indicate residents had been notified of Legionella in the water, risks of exposure to while showering and choices made to continue using the showers despite the risks. The DON and Administrator indicated all rooms, except on the vent unit, had their own bathrooms with showers. Residents on the vent unit could use the common shower room on the hall but most were provided bed baths. There were 63 private rooms with their own bathrooms and showers in the facility. The facility's water management program, dated 2024, indicated a Shower Risk Assessment indicated showers in resident rooms were a high risk location for Legionella bacteria due to stagnation of water in low use areas and aerolization of water in the showers.</p> <p>6/27/24-7/2/24 confidential interviews were conducted with 12 employees including Healthcare Providers who indicated they had not received training on Legionella or other waterborne illness. None had been instructed to monitor for symptoms of pneumonia in high risk residents (vent-dependent or residing in rooms where Legionella bacteria had been found). Many of the interviewed staff indicated not knowing what Legionella was, how it could cause infection and were not told to monitor respiratory symptoms in themselves and report to their supervisor. One Healthcare Provider indicated being told water samples were negative for Legionella bacteria.</p> <p>This tag relates to Complaint IN00437399.</p> <p>3.1-18(a)</p>		