

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER Serenity Spring Senior Living at Jasonville		STREET ADDRESS, CITY, STATE, ZIP CODE 800 E Ohio St Jasonville, IN 47438	

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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>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)</p> <p>Findings include:</p> <p>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.</p> <p>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.</p> <p>The Medication Administration Record (MAR), dated 11/28/24 through 12/4/24, indicated Macrobid 50 mg was administered at bedtime for UTI prevention.</p> <p>The quarterly MDS (Minimum Data Set) assessment, dated 12/4/24, lacked documentation of antibiotic use in the last seven days.</p> <p>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.</p> <p>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).</p> <p>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.</p> <p>A review of the Significant Change MDS assessment, dated 12/12/24, lacked documentation of UTI diagnosis.</p> <p>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.</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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER Serenity Spring Senior Living at Jasonville		STREET ADDRESS, CITY, STATE, ZIP CODE 800 E Ohio St Jasonville, IN 47438	
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 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>During an interview with the MDS nurse on 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.</p> <p>3.1-31(d)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER Serenity Spring Senior Living at Jasonville		STREET ADDRESS, CITY, STATE, ZIP CODE 800 E Ohio St Jasonville, IN 47438	
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>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).</p> <p>Finding includes:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>During an interview on 2/7/25 at 10:50 a.m., LPN 1 indicated there was no date on the oxygen tubing.</p> <p>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).</p> <p>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.</p> <p>The admission Minimum Data Set (MDS) assessment, dated 1/13/25, indicated oxygen therapy.</p> <p>A review of resident's care plan, initiated on 1/7/25, indicated the resident had oxygen therapy.</p> <p>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.</p> <p>The physician's orders lacked an order to change to oxygen tubing.</p> <p>The clinical record lacked documentation the oxygen tubing had been changed.</p> <p>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.</p> <p>3.1-47(a)(6)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155303	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2025
NAME OF PROVIDER OR SUPPLIER Serenity Spring Senior Living at Jasonville		STREET ADDRESS, CITY, STATE, ZIP CODE 800 E Ohio St Jasonville, IN 47438	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>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.</p> <p>Findings include:</p> <p>On 2/4/25 at 10:17 a.m., during the initial tour of kitchen with the Dietary Manager (DM), the following was observed:</p> <ul style="list-style-type: none"> - The refrigerator by the serving line had a pitcher 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. <p>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 .</p> <p>3.1-21(i)(2)</p> <p>3.1-21(i)(3)</p>