STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUBURN SENIOR LIVING, LLC	1675 W SEVENTH STREET, AUBURN, , 46706

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes 470068, 470107, 470160, and 470412. Intake 470068 - No deficiencies related to the allegations are cited. Intake 470107 - Nodeficiencies related to the allegations are cited. Intake 470160 - No deficiencies related to the allegations are cited. Intake 470412 - State deficiencies related to the allegations are cited at R0028. Survey date: June 29, 2026 Facility number: 014775 Residential Census: 78 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000		

	Quality review completed July 1, 2026.			
R 0028	Residents' Rights - Deficiency 410 IAC 16.2-5-1.2(c) (c) Residents have the right to exercise any or all of the enumerated rights without: (1) restraint; (2) interference; (3) coercion; (4) discrimination; or (5) threat of reprisal; by the facility. These rights shall not be abrogated or changed in any instance, except that, when the resident has been adjudicated incompetent, the rights devolve to the resident ' s legal representative. When a resident is found by his or her physician to be medically incapable of understanding or exercising his or her rights, the rights may be exercised by the resident ' s legal representative. Based observation, interview and record review, the facility failed to ensure a resident was able to exercise her rights without interference from staff for 1 of 3 residents reviewed (Resident C).	R 0028	**R028 – Residents Rights** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident C was gotten up and dressed when staff were told of the funeral. Resident was out all day with family for the funeral. Returned to the community when the funeral was over. Employee is no longer working at the community. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** Any residents have the potential to be affected by the practice of their rights or wishes being infringed upon. **What measures will be put into place or what systematic changes the facility will make the ensure that the deficient practice does not recur;** All licensed nurses and CNAs	07/31/2026

	Findings include: On 6/29/26 at 12:48 P.M., Resident C's record was reviewed. Diagnoses included diabetes and history of multiple fractures of her spine. A Brief Interview Mental Status (BIMS) exam, dated 6/25/26, indicated the resident had no cognitive impairment and was interviewable. A Service Plan, updated 6/25/26, indicated Resident C required assistance with getting in and out of bed and getting dressed. A progress note, dated 6/22/26 at 12:44 p.m., indicated Resident C made an allegation of being mistreated on 6/19/26. The resident reported the morning of 6/19/26 she was up very early to get ready to go to a funeral. She rang for staff assistance and when staff came into her room, she explained why she was up. The staff member allegedly told her funerals don't go on at that time of the morning and she needed to go back to bed. She refused and the staff member put her back into bed. When asked if the resident was hurt by the staff member, she indicated her back hurt but it was an on-going problem. A skin assessment was completed and there were no bruises, redness, or marks		will be educated by RSD or designee by July 31,2026 on resident rights and honoring their rights and wishes. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e, what quality assurance program will be put into place.** RSD or designee will conduct five resident interviews a week for six months to ensure that the residents feel their rights and wishes are being honored throughout the community. Findings will be reviewed at the QAPI meeting and updated if needed. **By what date the systemic changes will be completed.** July 31, 2026	

observed.

On 6/29/26 at 2:28 P.M., the facility's investigation of Resident C's allegation indicated Certified Nurse Aid (CNA) 2, caring for the resident the morning of the alleged incident, indicated she had gone into the resident's room and observed her seated in her wheelchair next to the bed. The resident indicated she had a funeral to go to and wanted to get dressed. CNA 2 asked the Qualified Medication Aid (QMA) 5 if the resident was going to a funeral later in the day. QMA 5 wasn't aware of the resident going out early for the day and suggested assisting the resident back into bed. CNA 2 indicated she told the resident to put her arms around her and she would transfer her back into bed. She indicated later, after putting the resident back into bed, she was told the resident was going to a funeral and would be leaving the facility early to travel.

QMA 5's statement regarding the incident indicated she had not been told the resident was to be up early to go to a funeral. The QMA went to the resident's room around 3:30 a.m. on 6/19/26 to get her blood sugar checked when the resident said she needed to get up and get ready. The QMA suggested she go back to bed. Around 5:30

a.m., she received a call indicating the resident was to be up and ready by 6:00 a.m. to travel south for a funeral. The QMA indicated as soon as she received the call, she told CNA 2 to assist her up and get dressed.

On 6/29/26 at 2:43 P.M., Resident C was interviewed. She was observed sitting on her couch in her living room. She spoke slowly and carefully when responding to questions about the allegations. She indicated she woke up around 3:30 a.m. on 6/19/26 and requested assistance with getting dressed. Her daughter was coming to pick her up early to travel some distance for a funeral. She was standing with her walker next to her bed and needed assistance getting her shirt on. The CNA came into her room and started arguing with her, telling her it was too early to get up for a funeral. The resident tried to explain why she was up so early but the CNA wouldn't listen to her and told her she needed to go back to bed. Resident C refused and the CNA then picked her up and put her into bed. When asked, she indicated the CNA picked her up like a "baby" and put her into bed. She indicated her back hurt after being put into bed but the pain was chronic. The resident indicated it had made her angry

	the CNA had not believed her and then put her into bed. She hadn't moved from the bed until her daughter arrived at the facility to pick her up. She indicated she had not seen the CNA again and had been reassured by staff, the CNA no longer worked at the facility. During an interview, on 6/29/26 at 2:28 P.M., the Regional Director of Clinical Services (RDCS) indicated CNA 2 had been immediately suspended pending investigation of the allegations. Following the investigation, CNA 2 was terminated from her employment. Staff were expected to provide care according to resident wishes and it was their right. A current policy, titled "Resident Rights" was provided by the RDCS on 6/29/26 at 4:26 P.M. The policy indicated residents had the right to have their rights recognized by the community including the right to direct his or her own care and the right to exercise free choices regarding activities and schedule. This Citation relates to Intake 470412.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR	TITLERegional director of	(X6) DATE07/24/2026

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREEllen Verardi	clinical servies	