

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/04/2026
NAME OF PROVIDER OR SUPPLIER AUBURN SENIOR LIVING, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 a Post Survey Revisit (PSR) to the State Residential Licensure Survey and the Investigation of intake 469008 completed on 4/8/2026. Intake 469008 corrected Survey date: May 4, 2026 Facility number: 14775 Residential Census: 79 Astral of Auburn was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey. Quality review completed May 6, 2026	R 0000			
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 PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	