STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/01/2025

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 a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00455914. Complaint IN00455914 - No deficiencies related to the allegations are cited. Survey dates: March 31 and April 1, 2025 Facility number: 014775 Residential Census: 79 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed April 2, 2025	R 0000		
R 0356	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(i)(1-8) (i) A current emergency information file shall be immediately accessible	R 0356	Corrective Action for Affected Resident(s): Immediate review and correction of	05/01/2025

	for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on interview and record review the facility failed to ensure emergency files were accurately completed for 5 of 5 residents reviewed. (Resident 10, Resident 20, Resident 30, Resident 50, and Resident 70). Findings include: During an interview ,on 4/1/25 at 9:19 AM, the Director of Nursing		the emergency file book for all residents. Staff responsible for completing emergency file book were re-educated on documentation standards and requirements. Systemic Changes: The emergency file book was audited and updated to ensure accuracy and completeness. New staff training includes specific instruction on emergency file requirements. Monitoring and Compliance: The Administrator or designee will audit the emergency file book weekly for 60 days, then monthly for three months. Audit results will be reviewed during QAPI meetings for continuous improvement.	

(DON) presented a binder indicating it contained current emergency files for all residents residing in the facility.

1) Resident 10's record was reviewed on 4/1/25 at 10:15 AM. Diagnoses included adjustment disorder with anxiety, essential hypertension, and depression.

A review of the emergency file book did not include an emergency document for Resident 10.

2) Resident 20's record was reviewed on 3/31/25 at 1:06 PM. Diagnoses included atherosclerotic disease of native coronary artery without angina pectoris, unspecified atrial flutter, chronic diastolic (congestive) heart failure, and major depression. Resident 10 had allergies to amoxicillin, aspirin, atomoxetine, clindamycin and Augmentin.

A review of Resident 20's document in the emergency file binder did not include Resident 20's allergies, a phone number for Resident 20 or his responsible party, a hospital preference, or a copy of his advanced directives.

3) Resident 30's record was reviewed on 3/31/25 at 1:33 PM. Diagnoses included type 2 diabetes mellitus without complications, unspecified atrial

	fibrillation and obstructive reflux uropathy. A review of the emergency file book did not include an emergency document for Resident 30. 4) Resident 50's record was reviewed on 3/31/25 at 2:02 PM. Diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, chronic obstructive pulmonary disease, and chronic kidney disease, stage 3. Allergies included cefadroxil, codeine, propoxyphene, Darvon, Keflex, and sulfa antibiotics. A review of Resident 50's document in the emergency file did not include Resident 50's allergies, hospital preference, or a copy of her advanced directives. 5) Resident 70's record was reviewed on 3/31/25 at 2:30 PM. Diagnoses included Alzheimer's disease with early onset, mood disorder due to known physiological condition, chronic kidney disease stage 3. A review of the emergency file book did not include an emergency document for Resident 70. In an interview, on 4/1/25 at 10:23 AM, the DON indicated			

	the print date on the documents in the binder was 3/4/24, so any resident admitted after that date would not have been included in the binder. She indicated the binder should have been kept current. She indicated residents' information should be added to the binder at the time of admission and updated when changes occur. She indicated all emergency files should have current phone numbers for residents and their representatives, allergies, hospital preference and code status information. She indicated all residents in the building should have current emergency information in the binder. A current policy dated 3/1/21 provided by the DON on 4/1/25 at 11:38 AM indicated designated staff should gather resident files and information when an emergency occurs. Resident information should include resident name, gender, any resident conditions or assistance needed, and representative contact information. Based on interview and record review the facility failed to ensure emergency files were accurately completed for 5 of 5 residents reviewed. (Resident 10, Resident 20, Resident 30, Resident 50, and Resident 70).			

Findings include:

During an interview ,on 4/1/25 at 9:19 AM, the Director of Nursing (DON) presented a binder indicating it contained current emergency files for all residents residing in the facility.

1) Resident 10's record was reviewed on 4/1/25 at 10:15 AM. Diagnoses included adjustment disorder with anxiety, essential hypertension, and depression.

A review of the emergency file book did not include an emergency document for Resident 10.

2) Resident 20's record was reviewed on 3/31/25 at 1:06 PM. Diagnoses included atherosclerotic disease of native coronary artery without angina pectoris, unspecified atrial flutter, chronic diastolic (congestive) heart failure, and major depression. Resident 10 had allergies to amoxicillin, aspirin, atomoxetine, clindamycin and Augmentin.

A review of Resident 20's document in the emergency file binder did not include Resident 20's allergies, a phone number for Resident 20 or his responsible party, a hospital preference, or a copy of his advanced directives.

3) Resident 30's record was

	reviewed on 3/31/25 at 1:33 PM. Diagnoses included type 2 diabetes mellitus without complications, unspecified atrial fibrillation and obstructive reflux uropathy. A review of the emergency file book did not include an emergency document for Resident 30. 4) Resident 50's record was reviewed on 3/31/25 at 2:02 PM. Diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, chronic obstructive pulmonary disease, and chronic kidney disease, stage 3. Allergies included cefadroxil, codeine, propoxyphene, Darvon, Keflex, and sulfa antibiotics. A review of Resident 50's document in the emergency file did not include Resident 50's allergies, hospital preference, or a copy of her advanced directives. 5) Resident 70's record was reviewed on 3/31/25 at 2:30 PM. Diagnoses included Alzheimer's disease with early onset, mood disorder due to known physiological condition, chronic kidney disease stage 3. A review of the emergency file book did not include an emergency document for			

	Resident 70. In an interview, on 4/1/25 at 10:23 AM, the DON indicated the print date on the documents in the binder was 3/4/24, so any resident admitted after that date would not have been included in the binder. She indicated the binder should have been kept current. She indicated residents' information should be added to the binder at the time of admission and updated when changes occur. She indicated all emergency files should have current phone numbers for residents and their representatives, allergies, hospital preference and code status information. She indicated all residents in the building should have current emergency information in the binder. A current policy dated 3/1/21 provided by the DON on 4/1/25 at 11:38 AM indicated designated staff should gather resident files and information when an emergency occurs. Resident information should include resident name, gender, any resident conditions or assistance needed, and representative contact information.			
R 0409	Infection Control - Noncompliance 410 IAC 16.2-5-12(d)	R 0409	Corrective Action for Affected Resident(s):	05/01/2025

	(d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on interview and record review, the facility failed to ensure annual health statements were maintained for 2 of 5 residents reviewed (Resident 20 and Resident 50). Findings include: 1) Resident 20's record was reviewed on 3/31/25 at 1:06 PM. Diagnoses included atherosclerotic disease of native coronary artery without angina pectoris, unspecified atrial flutter, chronic diastolic (congestive) heart failure, and major depression. A review of current physician orders did not include a statement indicating Resident 20 was free from communicable disease including tuberculosis in an infectious state.		Immediate review of all resident files to ensure health statements, including history of infectious diseases and TB screening, are present and complete. Any missing or incomplete health information was obtained from residents' physicians or appropriate medical providers and updated in the charts. Systemic Changes: Admissions staff were re-educated on the requirement that all residents must have a complete health statement, including infectious disease history and tuberculosis clearance, prior to admission. A pre-admission checklist is used to verify completion of all required health documentation before move-in. Monitoring and Compliance: The Resident Service Director or designee will audit new admissions weekly for 60 days, then monthly for three months to ensure compliance with health statement requirements. Audit findings will be reviewed during QAPI meetings to monitor ongoing compliance.	

A review of progress notes from 4/1/24 to 4/1/25 did not include a statement from a provider indicating Resident 20 was free from communicable disease including tuberculosis in an infectious state..

2) Resident 50's record was reviewed on 3/31/25 at 2:02 PM. Diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, chronic obstructive pulmonary disease, and chronic kidney disease, stage 3.

A review of current physician orders did not include a statement indicating Resident 50 was free from communicable disease including tuberculosis in an infectious state.

A review of progress notes from 4/1/24 to 4/1/25 did not include a statement from a provider indicating Resident 50 was free from communicable disease including tuberculosis in an infectious state.

In an interview, on 4/1/25 at 10:13 AM, the Director of Nursing indicated freedom from communicable disease including tuberculosis in an infectious state should be included in the physician orders section of the electronic medical record. She indicated the statement should

be included at the time of admission and reviewed monthly.

A current policy titled Resident Move-IN Checklist, undated, provided by the DON on 4/1/25 at 10:23 AM indicated documentation of the resident being free of communicable disease including tuberculosis in an infectious state should be included in the medical record.

Based on interview and record review, the facility failed to ensure annual health statements were maintained for 2 of 5 residents reviewed (Resident 20 and Resident 50).

Findings include:

1) Resident 20's record was reviewed on 3/31/25 at 1:06 PM. Diagnoses included atherosclerotic disease of native coronary artery without angina pectoris, unspecified atrial flutter, chronic diastolic (congestive) heart failure, and major depression.

A review of current physician orders did not include a statement indicating Resident 20 was free from communicable disease including tuberculosis in an infectious state.

A review of progress notes from 4/1/24 to 4/1/25 did not include a statement from a provider indicating Resident 20 was free

from communicable disease including tuberculosis in an infectious state..

2) Resident 50's record was reviewed on 3/31/25 at 2:02 PM. Diagnoses included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, chronic obstructive pulmonary disease, and chronic kidney disease, stage 3.

A review of current physician orders did not include a statement indicating Resident 50 was free from communicable disease including tuberculosis in an infectious state.

A review of progress notes from 4/1/24 to 4/1/25 did not include a statement from a provider indicating Resident 50 was free from communicable disease including tuberculosis in an infectious state.

In an interview, on 4/1/25 at 10:13 AM, the Director of Nursing indicated freedom from communicable disease including tuberculosis in an infectious state should be included in the physician orders section of the electronic medical record. She indicated the statement should be included at the time of admission and reviewed monthly.

A current policy titled Resident

	Move-IN Checklist, undated, provided by the DON on 4/1/25 at 10:23 AM indicated documentation of the resident being free of communicable disease including tuberculosis in an infectious state should be included in the medical record.			

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