STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155666	A. Building B. Wing	10/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Auburn Village	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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure respectful and dignified communication and care for 1 of 3 residents reviewed. (Resident A)A record review for Resident A's began on 10/16/25 at 9:30 AM. Diagnoses included anxiety, depression, and respiratory failure.A review of Resident A's current quarterly MDS, dated [DATE], indicated their BIMS (Basic Interview for Mental Status) score was 15 (cognitively intact). The MDS indicated the resident had a tracheostomy and ventilator. A review of Resident A's current Care Plan indicated Resident A had potential to be manipulative, exhibit attention-seeking behaviors, and display emotional overreaction to minor events. Interventions included calm, consistent communication with firm boundaries.A review of Resident A's current Care Plan indicated Resident A had a problem of an anxiety disorder. Resident A could have racing thoughts, feel overwhelmed, and stressed. Interventions included encourage Resident A to engage in deep breathing exercises, grounding techniques, and mindfulness when resident was feeling anxious. In an interview, on 10/16/25 at 9:55 AM, the Director of Nursing (DON) indicated on 9/21/25, CNA 2 had expressed concern about Resident A's respiratory distress to RN 3. RN 3 had indicated they didn't care and Resident A needed to quit yelling. CNA 2 relayed RN 3's comment to Resident A.A review of progress notes, dated 9/21/2025 at 9:54 AM, indicated Resident A continued to refuse ADL care from available CNAs, there were currently 2 aides on the floor and the other aide was providing care for another resident. Resident A DEMANDED to be changed right now, the aide that was not assigned to Resident A attempted to provide ADL care and Resident A refused. The writer attempted to explain, Resident A began screaming at staff and called the DON. Staff removed their attention as the resident was safe.In an interview, on 10/16/25 at 12:58 PM, CNA 2 indicated Resident 2 appeared they may have been choking or unable to breath well. CNA 2 indicated they expressed concern and urgency to RN 3 about breathing status. RN 3 indicated they didn't care and wasn't going to check on Resident A. Resident A had asked about what had taken place outside of the room. CNA 2 had repeated what the RN 3 had said about not caring. In an interview, on 10/16/25 at 1:09 PM, RN 3 indicated they were the charge nurse on 9/21/25 during the day shift. Resident A had been verbally upset. Resident A calmed down when CNA 2 went into Resident A's room to provide care. CNA 2 came out of the room and indicated Resident A couldn't breathe. RN 3, another nurse, and a respiratory therapist were at the nurses' station. RN 3 indicated they weren't going down there to check on Resident A. CNA 2 went back to Resident A's room. The respiratory therapist went to Resident A approximately 30 seconds after CNA 2.In an interview, on 10/16/25 at 2:10 PM, Resident A indicated RN 3 had entered the room and an upsetting exchange occurred. Resident A indicated they would call the DON, RN 3 indicated they would call her too. Resident A indicated they had anxiety, crying, was breathing fast, and needed help when CNA 2 came in.A current policy dated 10/2021, provided by the Administrator, indicated that all residents should be treated with dignity in which the staff assist with activities of daily living such as dressing, bathing, and incontinent care. All residents should be respected for their individuality, their views, and the way in which they are accustomed to conduct their lives. Staff should always treat residents with sensitivity, respect, and thoughtfulness. Staff should always treat residents in a dignified and sensitive way when performing intimate care tasks.This citation is related to intake 2624266.3. 1-3(a)