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	07/02/2024

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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45794 Based on observation, interview and record review the facility failed to identify, assess and determine underlying cause of specific expressions of distress of a trauma survivor for 1 of 2 residents reviewed (Resident 3). Findings include: On 6/27/24 at 12:10 PM, Resident 3 was observed sitting in the doorway of their room in their wheelchair. Resident 3 greeted a staff member pleasantly. Resident 3 greeted this writer, then quickly looked away. Resident 3 began to speak softly in nonsensical terms while looking at the palms of their hands. Resident 3's record was reviewed on 7/1/24 at 11:36 AM. Resident 3's diagnoses included anxiety, major depressive disorder, paranoid schizophrenia, insomnia, obsessive compulsive disorder, morbid obesity, tracheostomy, (surgical opening for breathing) mechanical ventilator (breathing machine) at night. Resident 12 was a survivor of childhood sexual trauma. Resident 3's Annual Minimum Data Set (MDS) dated [DATE] indicated the resident's Brief Interview for Mental Status (BIMS) score was 12 (mild cognitive impairment). The MDS indicated Resident 3 had not displayed any behaviors related to delusions, aggression or resistance of care. A progress note dated 8/23/23 at 4:07 PM indicated Resident 3 had been swearing and being sexually inappropriate. A Psychiatric Nurse Practitioner (NP) progress note dated 10/12/23 and signed 10/15/23 at 11:53 AM indicated Resident 3 had a history of sexually inappropriate comments and sexually inappropriate behaviors. Resident 3 had a history of physical and verbal aggression. Resident 3 had a history of abuse and/or neglect as a victim and as a perpetrator. A progress note dated 11/19/23 at 4:55 PM indicated Resident 3 often spoke in delusional fantasy themed conversations. A progress note dated 12/3/23 at 2:00 AM indicated Resident 3 refused their shower. Resident 3 had reported they did not want a man to assist with their shower. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 1/6/24 at 4:16 AM indicated Resident had been verbally aggressive and had shoved their bedside table into the hallway. A progress note dated 1/6/24 at 6:10 PM indicated Resident 3 had been begging the staff to buy them alcohol. A progress note dated 1/7/24 at 6:20 AM indicated Resident 3 had made inappropriate sexual comments about a staff member's wife. A progress note dated 4/28/24 at 9:40 PM indicated Resident 3 made an inappropriate sexual comment to a staff member. A progress note dated 5/2/24 at 12:58 AM indicated Resident 3 had been making derogatory sexual comments and blaring loud music from their room. Resident 3 did not respond to redirection attempts. A progress note dated 5/2/24 at 2:53 PM indicated Resident 3 had been administered lorazepam due to increased behaviors and agitation. A progress note dated 5/15/24 at 4:35 PM indicated Resident 3 had been evaluated by the Psychiatric NP for yelling in the halls and increased behaviors. A Psychiatric NP progress note dated 11/29/23 and signed on 12/2/23 at 10:14 AM indicated Resident 3 had been obsessively focusing on their diet. A Psychiatric NP progress note dated 2/11/24 and signed 2/13/24 at 6:47 AM indicated Resident 3 had been frustrated because the resident had wanted a second meal tray before finishing their first meal. A Psychiatric NP progress note dated 5/15/24 at 7:27 PM indicated Resident 3 had been evaluated for increased delusions, hallucinations, anxiety, agitation and paranoia. Resident 3 had been yelling out and being inappropriate. A Psychiatric NP progress note dated 5/26/24 at 3:39 PM indicated Resident 3 continued to have anxiety while wearing their ventilator. Resident 3 had been prescribed lorazepam to be administered every 4 hours. A Psychiatric NP progress note dated 6/12/24 and signed 6/13/24 at 3:47 PM indicated Resident 3 had been evaluated for concerns of anxiety, depression, insomnia and a fixation on pickles. Resident 3's care plan dated 5/24/23 indicated the resident was a childhood sexual abuse survivor. The target goal was for Resident 3 to have minimal trauma related stress or anxiety by 9/24/24. Interventions included Resident 3 did not have any known triggers, avoidance of trauma related topics, providing support and assurance of safety. Resident 3's care plan dated 1/28/23 indicated the resident soaked their laundry in the sink, put their clothing on the floor and ate with their fingers. The target goal was Resident 3 would not soak their clothing in their sink through 9/24/24. Interventions included documentation of behaviors, praise for appropriate behavior, remind to use the facility laundry service. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3's care plan dated 1/16/24 indicated Resident 3 refused to reduce clutter in their room. The target was for the resident to make informed choices and be aware of outcomes of resisting care by 9/24/24. Interventions included a calm approach, offer storage containers, allow the resident to maintain control. Resident 3's care plan dated 3/31/22 indicated the resident sometimes removed all the snacks from the resident pantry. The target was for the resident to have decreased behaviors by 9/24/24. Interventions included encouragement to take appropriate portions, redirection, praise for good behavior and mental health services as needed. Resident 3's care plan dated 11/7/23 indicated the resident would sometimes engage in self-gratification. The target was for the resident to be provided with privacy through 9/24/24. Interventions included positive reinforcement for appropriate behavior, encourage activities to decrease boredom, maintain safety, preserve dignity, if Resident 3 engages in self-gratification during care; immediately stop care and step away, use an opposite sex caregiver when necessary, close door and allow privacy. Resident 3's care plan dated 6/27/23 indicated the resident had a disturbed sleep pattern due to insomnia. The target was for the resident to report they feel rested through 9/24/24. Interventions included a restful environment, discouraging daytime naps, maintaining a bedtime routine and a bedtime snack. Resident 3's care plan dated 12/14/21 indicated the resident sometimes had aggressive behaviors such as throwing objects, throwing food, using racial slurs and making sexual comments. The target was for the resident to have decreased aggressive behaviors through 9/24/24. Interventions included approaching in a calm manner, alternating different staff, offering simple choices, approaching later, and providing education. Resident 3's care plan dated 1/26/22 indicated the resident was sometimes resistant to care. The target was for the resident to not have a functional decline through 9/24/24. Interventions included allowing choices, praise for appropriate behavior, avoiding power struggles, approaching later and providing education related to consequences of noncompliance. Resident 3's care plan did not address obsessive compulsive disorder or depression, interventions to identify and assess specific stressors, include pain as a possible stressor for aggression, nor include male caregivers as a possible stressor for refusal of care. In an interview on 7/2/24 at 11:56 AM, the Social Service Director (SSD) indicated they were aware of Resident 3's increased behaviors. The SSD indicated Resident 3's behaviors were reviewed in daily morning meetings and interdisciplinary (IDT) meetings. The SSD indicated specific behavioral triggers were attempted to be identified during IDT meetings. The SSD indicated Resident 3 denied specific triggers related to their history of trauma. The SSD indicated direct care staff were made aware of Resident 3's specific behaviors on daily assignment sheets. In an interview on 7/2/24 at 2:20 PM the Director of Nursing (DON) indicated Resident 3 had denied trauma related triggers. The DON indicated Resident 3 had refused to speak about their trauma history. The DON indicated they agreed stressors could be identified by other means than self-report. The DON indicated they agreed triggers could be identified by staff observances. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3's Profile Care Plan Approach (used by direct care staff to provide resident care) provided by the Administrator on 7/2/24 at 2:15 PM indicated topics related to the resident's trauma should be avoided. The care plan approach did not include specific traumatic topics to be avoided. The care plan approach did not include specific stressors for aggression or resistance to care. A current facility policy dated 5/17 provided by the Social Service Director on 7/1/24 at 3:20 PM indicated the facility would identify experiences and symptoms that may indicate trauma. A current facility policy dated 2/22 provided by the Administrator on 7/1/24 at 4:10 PM indicated residents would be referred to behavioral health services in accordance with their comprehensive assessment and their plan of care. Symptoms of post-traumatic stress disorder (PTSD) can include insomnia, anxiety, and avoidance of thoughts or feelings associated with the event (NIMH, 2024). Risk factors for PTSD include exposure to traumatic events and a history of mental illness. Survivors of childhood sexual trauma have a higher prevalence of anxiety, depression and post-traumatic stress disorder, (National Center for PTSD, 2023) hoarding (and eating disorders (Journal of Eating Disorders, 2023). References National Institute of Mental Health, (nimh.nih.gov, 2024). https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd The National Center of PTSD, (ptsd.gov, 2023). https://www.ptsd.va.gov/understand/types/sexual_trauma_male.asp The Journal of Eating Disorders, (2023). https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-023-00819-7 3.1-43(a)(1)