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	06/17/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure dining choices were respected for 1 of 8 residents reviewed (Resident 60). Findings include: During an observation on 6/11/25 at 11:35 AM, Resident 60 was observed seated at a table in the assisted dining room with two other residents. Three staff members were seated at the table assisting the residents with their lunch. During an observation on 6/12/25 at 11:56 AM, Resident 60 was observed seated at a table in the assisted dining room with two other residents. Three staff members were seated at the table assisting the residents with their lunch. During an interview on 6/12/25 at 10:47 AM Resident 60 indicated he had notified staff during a resident council meeting he wished to dine in the main dining room, so he had the opportunity to meet more residents and increase his socialization. He indicated he had expressed to staff he would like to have the choice of where to dine. During an interview on 6/12/25 at 11:32 AM, Registered Nurse (RN) 2 indicated residents could choose which dining room they prefer to sit in. She indicated while no residents were currently aided in the main dining room, residents had been provided assistance there in the past. She indicated some residents preferred not to be assisted in front of others who were not being assisted, but ultimately, the resident could make that decision. During an interview on 6/12/25 at 1:32 PM Resident 60 indicated the Activities Director (AD) told him a few days after the resident council meeting, he was not allowed to eat in the main dining room because he required assistance, and it was a dignity issue. Resident 60 indicated he was comfortable having others observe him receiving feeding assistance. In an interview on 6/12/25 at 2:01 PM, the Activity Director indicated Resident 60 had expressed his desire to eat in the main dining room during a resident council meeting around the first week of June. She indicated the Administrator and corporate staff had told her it was a dignity issue, and he must eat in the assisted dining room. She indicated she reported to Resident 60 that he would not be able to eat in the main dining room due to dignity issues. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/13/25 at 10:29 AM, the Director of Nursing indicated Resident 60 was placed in the assisted dining room due to safety issues. She indicated the facility had plenty of staff available at each meal to assist each resident needing assistance to eat. She did not indicate what safety issues could not be handled in the main dining room. Resident 60's record was reviewed on 6/12/25 at 11:07 AM. Diagnoses included muscular dystrophy and major depressive disorder. A review of Resident 60's current quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated his Basic Interview for Mental Status (BIMS) score was 15 indicating he was cognitively intact and able to make daily decisions. The MDS indicated Resident 60 required assistance with eating and did not display signs and symptoms of a swallowing disorder or concerns about safety with dining. A review of Resident 60's current care plan titled Resident is independent with activities indicated the resident had a problem of independence with activities, with a goal date of 9/1/25. Interventions included ensuring activities were compatible with known interests and preferences. The care plan indicated resident interests should be established by talking with the resident as needed. A care plan intervention was added on 6/13/25 indicating Resident 60 required total assist with eating and all meals were to be in the Assisted Dining Room as the resident would allow. The care plan did not address Resident 60 having a choice of which dining area to dine in. A Quarterly Nutrition Review, dated 5/30/25, indicated Resident 60 did not display a chewing or swallowing problem and did not indicate a preferred dining location. A review of physician orders dated 11/25/24 indicated Resident 60 received a regular diet with regular/thin consistency fluids. In a Psychotherapy progress note dated 6/3/25 at 6:45 PM, Licensed Social Worker 8 indicated Resident 60 had expressed not having much going on lately and struggling with being young in the facility atmosphere. The note did not indicate the resident was requesting to eat in the main dining room for socialization. A current policy dated 10/21 provided by the Administrator on 6/16/25 at 1:38 PM indicated all residents should be consulted on any matter or activity which may impinge on their life within the facility in any way, and to have their wishes respected. 3.1-3(u)(1) 3.1-3(u)(1)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview and record review, the facility failed to ensure the treatment to maintain or prevent further loss of range of motion for 1 of 1 resident reviewed (Resident 7). Findings include: In an interview, on 6/11/25 at 10:23 AM, Resident 7 indicated they were unable to participate in bingo due to limited use of their hands. On 6/11/25 at 10:25 AM, Resident 7 was observed to have contractures (rigid joints) of both of their wrists. Resident 7's record was reviewed on 6/16/25 at 9:36 AM. Diagnoses included rheumatoid arthritis (a condition that causes stiff joints) and Parkinson's Syndrome (a condition that affects movement and coordination due to stiffness and tremors). Resident 7's Quarterly Minimum Data Set, (MDS)dated 5/20/25 indicated their Brief Interview of Mental Status (BIMS) score was 2 (severe cognitive impairment). The MDS indicated Resident 7 required substantial to maximum staff assistance for eating. The MDS indicated Resident 7 was dependent on staff assistance for oral care, mobility, bathing and toileting. The MDS indicated Resident 7 had no impairment of functional range of motion to their shoulders, elbows, wrists or hands. The MDS indicated Resident 7 had no impairment of functional range of motion to their hips, knees, ankles or feet. Resident 7's care plan, dated 3/24/25, indicated the resident had limited physical mobility due to Parkinson's, Alzheimer's, rheumatoid arthritis and contracted feet. The target goal was for the resident to remain free from immobility complications including further contractures through 7/13/25. Interventions included provision of daily gentle range of motion as tolerated. Resident 7's Medication Administration Record (MAR) dated 6/1/25 through 6/17/25 did not indicate the resident had received range of motion exercises. Resident 7's Treatment Administration Record (TAR) dated 6/1/25 through 6/17/25 did not indicate the resident had received range of motion exercises. Resident 7's nurse aide task sheet did not indicate the resident had received range of motion exercises. In an interview, on 6/17/25 at 9:52 AM, the Director of Nursing (DON) indicated range of motion is documented by the nurse aides under the tasks tab. In an interview, on 6/17/25 at 11:45 AM, the DON indicated Resident 7's range of motion was not documented due to the facility not having an official restorative program. The DON indicated range of motion exercises were not documented due to range of motion was supposed to be automatically performed for all residents. The DON indicated according to a nurse aide training school, nurse aides were trained to perform range of motion during morning and evening care, therefore does not need to be recorded. The DON indicated the facility did not have an official policy for contracture care. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-42(a)(1) 3.1-42(a)(2)

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to ensure non-medication pain interventions were implemented as ordered by the physician for 1 of 1 resident reviewed (Resident 30). Findings include: Resident 30's record was reviewed on 6/16/25 at 10:56 AM. Diagnoses included chronic pain syndrome, low back pain, right leg pain and polyneuropathy (damage to multiple nerves). Resident 30's Quarterly Minimum Data Set, (MDS) date 4/11/25, indicated the resident's Brief Interview for Mental Status (BIMS) score was 14 (no cognitive impairment). The MDS indicated Resident 30 had not been administered routine pain medication. The MDS indicated Resident 30 had been administered pain medication as needed. The MDS indicated Resident 30 frequently had pain. The pain frequently interfered with Resident 30's sleep at night. The MDS indicated Resident 30 had not been offered non-medication pain interventions. Resident 30's care plan, dated 3/10/25, indicated the resident was at risk for pain due to impaired mobility, diabetes with polyneuropathy, chronic pain syndrome, low back pain, and end stage renal disease dialysis dependent and dorsalgia (back pain). The target goal was to have no interruption of normal activities due to pain through 8/17/25. Interventions included assessment of pain, assessment of effectiveness of pain medications, documentation of probable cause of each episode of pain and removal of causes when possible. A physician order, dated 4/10/25, indicated Resident 30 could be administered 2 tablets of hydrocodone-acetaminophen (Norco) every 6 hours as needed (PRN) for moderate to severe pain. A physician order, dated 11/26/24, indicated Resident 30 could be administered 2 tablets of acetaminophen (Tylenol) every 6 hours as needed (PRN) for mild to moderate pain. A physician order, dated 11/26/24, indicated the nurse should offer non-medication pain interventions prior to administering PRN pain medications. A physician order, dated 4/1/25, indicated Resident 30 would be assessed for pain every shift. Resident 30's MAR, dated 6/1/25 to 6/16/25, indicated the resident had been administered Norco for moderate to severe pain on 20 occasions. The MAR did not indicate the resident had been offered non-medication pain interventions. Resident 30's MAR, dated 6/1/25 to 6/16/25, indicated the resident had not been administered Tylenol for mild to moderate pain. Nursing notes, dated 6/1/25 to 6/15/25, did not indicate any non-pharmacologic interventions had been attempted for Resident 30, In an interview, on 6/16/25 at 2:00 PM, Registered Nurse (RN) 4 indicated non-medication pain interventions were documented in the MAR whenever a PRN pain medication was administered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview, on 6/17/25 at 9:52 AM, the Director of Nursing (DON) indicated non-medication pain interventions are recorded on the MAR when PRN pain meds are administered. The DON reviewed Resident 30's current MAR. The DON indicated non-medication pain interventions were not included in Resident 30's MAR. The DON reviewed Resident 30's physician orders and care plan. The DON indicated non-medication pain interventions were included in the resident's physician orders. The DON indicated specific non-medication pain interventions were not included in the resident's care plan. In an interview, on 6/17/25 at 11:40 AM, the DON, while referring to their phone, indicated a federal regulation did not require non-medication pain interventions. The DON indicated according to the regulation they had referred to; non-medication pain interventions could be a consideration and therefore, were not a requirement. A current facility policy, titled Pain Management, dated 11/2022, provided by the Assistant Director of Nursing on 6/16/25 at 1:54 PM, indicated a resident specific pain management care plan would be developed for each resident who has pain. The policy indicated both pharmacological and non-pharmacological interventions may be implemented. 3.1-37(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure kitchen cleanliness was maintianed. 70 of 81 residents residing in the facility ate food prepared in the kitchen. Findings include: During an observation, on 06/11/25 at 09:13 AM, there was moisture in 2 of 3 pans on drying rack, the stand mixer located in the cooking and clean storage area had yellow particles and yellow discoloration on the bowl, paddle, and on the main unit. An unlabeled fruit cup had a red liquid puddle underneath on the top drawer of the mini fridge in the south hall. Employee 9 had their hair unrestrained During an interivew, on 06/11/25 at 10:25 AM, The Dietary Manager indicated the kitchen staff needed to restrain their hair with a hairnet. During an observation, on 06/11/25 at 10:30 AM, Employee 9 took the lid off the food processor and placed it right side up on top of the toaster next to it. The top of the toaster had crumbs and dry brown particles on the top surface. The rim of the lid is an interior surface and touches the food inside the food processor. Food and liquid were transferred to the toaster by contact. During an observation, on 06/11/25 at 11:05 AM, the following was observed, in the dining room on the 200 hall brown stains were found on the floor under the coffee maker, and a dry, round, white food-like substance was found on the cabinet door next to the coffee maker. In an interview on, 06/11/25 at 10:30 AM, Employee 10 and the Dietary Manager were notified of the food and liquid from the inside of the food processor was transferred to the toaster. Employee 10 acknowledged they would have to clean the toaster and move it to a better storage location. The Dietary Manager indicated 70 of 81 residents residing in the facility ate food prepared on the facility kitchen. A current policy dated 06/12/25 provided by the Dietary Manager indicated that small appliances such as mixers and food processors should have solid food scraped into a garbage container, and to clean the outer surface with a clean cloth that has been moistened in hot, soapy water. A current policy dated 06/12/25 provided by the Dietary Manager indicated that food should be labeled with the date received, the date opened, and the date by which the item should be discarded. Once opened, these items are refrigerated and labeled with the date opened and with discard or use by date. 483.60(i)(1)(2)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure massage therapy was provided for 1 of 24 residents reviewed (Resident 60). Findings include: During an interview on 6/12/25 at 10:17 AM, Resident 60 indicated he had notified facility staff of desire to receive massage therapy services for discomfort related to muscular dystrophy. He indicated he could receive the services for free at the Veterans Affairs Hospital. He indicated he had inquired about massage therapy during a Resident Council meeting. After the meeting, the facility driver had told him the facility could not assist him with transportation due to it not being a medically necessary service, but the facility might be able to offer massage in house. He indicated the conversation was several weeks ago and he had not received any further information from the facility. During an interview on 6/12/25 at 1:32 PM, Resident 60 indicated he had not received any massage therapy from facility staff or heard of any plans to be provided with this service. Resident 60's record was reviewed on 6/12/25 at 11:07 AM. Diagnoses included muscular dystrophy and major depressive disorder. A review of Resident 60's current quarterly Minimum Data Set Assessment (MDS), dated [DATE], indicated their Basic Interview for Mental Status (BIMS) score was 15 (cognitively intact). The MDS indicated Resident 60 did not reject any care necessary to achieve his goals for health and well-being. The MDS indicated Resident 60 had limitations of range of motion in both upper extremities and required extensive physical assistance with activities of daily living. A review of Resident 60's current care plan titled Resident is Resistant to care such as wearing a gait belt indicated Resident 60 had a problem of resisting use of a gait belt with a goal date of 9/1/25. The care plan indicated Resident 60 should be allowed to make decisions about his treatment regimen to provide a sense of control. A current care plan titled resident is at risk for pain indicated Resident 60 had a problem of pain related to impaired mobility, benign prostatic hypertrophy, dorsalgia, muscular dystrophy, and irritable bowel syndrome. The care plan had a goal date of 9/1/25. Interventions included reporting complaints of pain or requests for pain treatment to the nurse. The care plan did not include interventions to relieve pain related to range of motion or massage therapy. A review of Resident Council Meeting Minutes dated 6/3/25 indicated the Nurse Practitioner spoke with Resident 60 to obtain preference and transportation related to going out to VA for massage therapy. A review of progress notes dated 5/28/25 at 1:11PM indicated Resident 60 reported persistent side neck pain for which he had received massages in the past. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of progress notes dated 6/6/25 at 1:25 PM indicated Resident 60 was referred to Physical Therapy for ultrasound and massage therapy to address discomfort with spinal curvature. The progress note indicated Nurse Practitioner (NP) 7 would monitor his condition and adjust treatment as necessary. A review of progress notes from 6/1/25 to 6/16/25 did not include any care refusals or refusals of offers of massage therapy. A review of active physician orders for 6/12/25 did not include an order for physical therapy. A physician's order dated 5/19/25 indicated Skilled Occupational Therapy was ordered 2 times a week for 5 weeks to include therapeutic exercise, self-care, neuromuscular reeducation, therapeutic activities, wheelchair management, and safety awareness. In an interview, on 6/13/25 at 1:03 PM, the Director of Nursing (DON) indicated Physical Therapy was not providing massage therapy to Resident 60. She indicated Resident 60 was on Occupational Therapy (OT) caseload, and OT was handling the massage therapy. In an interview on 6/13/25 at 1:11 PM the Director of Therapy indicated Resident 60 had not been evaluated for massage therapy, but would be evaluated for massage therapy that day. The Occupational Therapy Plan of Care indicated therapy goals for neck pain with the initiation of manual techniques began on 6/13/25. In an interview, on 6/16/25 at 12:07 PM, Qualified Medicine Aide (QMA) 3 indicated she managed facility-provided transportation. She indicated Resident 60 had asked her about massage appointments, but she did not have an appointment for massage therapy on her schedule for him. She did not indicate passing his inquiry on to any other employee. In an interview, on 6/17/25 at 11:30 AM, the DON indicated the discussion of massage therapy was not an order and was only discussed as a possibility. The DON did not indicate the resident had been reviewed for a Restorative Program including Active and Passive Range of Motion. In an interview, on 6/17/25 at 11:40 AM, NP 7 indicated she reviewed her progress note from 6/6/25 and indicated her note appeared to be an order for a Physical Therapy referral. She indicated she did not intend to write an order, but meant to have Physical Therapy discuss massage therapy. She indicated she had not spoken with the facility about rescinding the order. A current policy titled Physician's Orders, dated 3/16, provided by the Administrator on 6/16/25 at 1:38 PM, indicated new orders should be promptly entered into the computer and carried out. 3.1-23 (a)(1)(2)