STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING -- B. WING	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 7/29/21 Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570 At this Emergency Preparedness survey, Autumn Ridge Rehabilitation Centre was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 75 and had a census of 51 at the time of this survey. Quality Review completed on 08/03/21	E 0000	The creation of and submission of this plan of correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violations of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after August 28, 2021. We respectfully request a desk review in lieu of a post survey Revisit	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/29/21 Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570 At this Life Safety Code survey, Autumn Ridge Rehabilitation Centre was found not in compliance with Requirements for Participation in	K 0000	The creation of and submission of this plan of correction does not constitute admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violations of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and request a post survey review on or after August 28, 2021. We respectfully request a desk review in lieu of a post survey Revisit	

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

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This three story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor and hard wired smoke detectors in 9 resident rooms and the remaining resident rooms had battery operated smoke detectors. The facility has a capacity of 75 and had a census of 51 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached sheds used for storage of maintenance parts. Quality Review completed on 08/03/21			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 #1. Based on observation and interview, the facility failed to ensure 1 of 1 exit doors from the copier room only contained one latching mechanism to release the door and open. LSC 7.2.1.5.10 states a latch or other fastening device	K 0211	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws.	08/28/2021

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	on a door leaf shall be provided with a releasing device that has an obvious method of operation and that is readily operated under all lighting conditions. 7.2.1.5.10.4 states the releasing mechanism shall open the door leaf with not more than one releasing operation. 7.2.1.5.10.1 states the releasing mechanism for any latch shall be located not less than 34 inches, and not more than 48 inches, above the finished floor. This deficient practice could affect staff that use the copier room. Findings include: Based on observation with the Maintenance Director on 07/29/21 at 12:13 p.m., the copier room exit door was equipped with two latching devices, a latching door turn knob and a separate deadbolt lock. Based on interview at the time of observation, the Maintenance Director agreed the copier room exit door was equipped with two latching devices. #2 Based on observation and interview, the facility failed to ensure 1 of 3 means of egress on the second floor were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 10 residents on the second floor. Findings include: Based on observation with the Maintenance Director on 07/29/21 at 12:43 p.m., a resident bed, a shower bed, and a trash bin were stored in the 200-storage hall corridor. Based on interview at the time of the observation, the Maintenance Director agreed the means of egress were not continuously maintained free of all obstructions		K211 Means of Egress - General · **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** #1 Maintenance Director removed latching Mechanism #2 Items stored in the 200-storage hall corridor were removed · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected There are no other latching mechanisms in the facility. · **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance Director will monitor copier room door to ensure locking mechanism is still nonfunctioning. Staff were educated to ensure corridors stay clear in case of fire or another emergency · **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Ongoing compliance with this corrective action will be monitored through the facility QAPI Program,	

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	or impediments to full instant use in the case of fire or other emergency. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		with meetings being held monthly and overseen by the Executive director. The Executive Director or designee will document their findings on the Team QAPI Tool" weekly for 4 weeks, monthly for 3 months, and quarterly thereafter to ensure the policy/procedures are followed per facility policy. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow up. · **by what date the systemic changes for each deficiency will be completed.** 8-28-21	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times.			

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	18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted			

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	on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 stair exits on the third floor were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 30 residents, staff, and visitors if needing to exit the facility in an emergency on the third floor. Findings include: Based on observation with the Maintenance Director on 07/29/21 at 1:13 p.m., the three exit stair doors were marked as a facility exit, were magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted at the exit. Based on interview at the time of observation, the Maintenance Director agreed the code to open the three exit doors were not posted by the access control pad. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0222	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. K222 Egress Door **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Maintenance director posted the four-digit code on the access control pad at the exit on the keypads identified. **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected Facility audited four-digit code posted on access control pad at exit doors will continue to monitor during morning GEMBA rounds **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Maintenance Director or designee will ensure the four-digit code stays posted on the access	08/28/2021

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	155162	A. BUILDING 01 B. WING	07/29/2021

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			control pad on at the exit on the keypads identified. **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Ongoing compliance with this corrective action will be monitored through the facility QAPI Program, with meetings being held monthly and overseen by the Executive director. The Executive Director or designee will document their findings on the Team "QAPI Tool" weekly for 4 weeks, monthly for 3 months, and quarterly thereafter to ensure the policy/procedures are followed per facility policy. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow up. **by what date the systemic changes for each deficiency will be completed.** 8-28-21	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.			

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	19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview, the facility failed to ensure 1 of 3 exit paths had exit signs that were not obstructed from view. This deficient practice could affect 30 residents on the third floor. Findings include: Based on observation with the Maintenance Director on 07/29/21 at 1:43 p.m., upon inspection of the 300-hall smoke wall, the exit sign was located above the ceiling tiles and could not be seen when the ceiling tiles were in place. Based on an interview at the time of observation, the Maintenance Director agreed the exit sign was above the ceiling tiles and stated the sign must not have been reinstalled on the new ceiling tile after replacement of the tile. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0293	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. K293 Exit Signage · **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Maintenance director removed sign from above ceiling tiles. Exit sign is now in visual sight and in proper placement. keypads identified. · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected Maintenance Director audited facility to ensure there were no other directional signs or emergency lighting obstructed from view. · **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Maintenance Director or designee will audit area to ensure	08/28/2021

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			the exit sign stays in proper placement. · **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Ongoing compliance with this corrective action will be monitored through the facility QAPI Program, with meetings being held monthly and overseen by the Executive director. The Executive Director or designee will document their findings on the Team "QAPI Tool" weekly for 4 weeks, monthly for 3 months, and quarterly thereafter to ensure the policy/procedures are followed per facility policy. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow up. · **by what date the systemic changes for each deficiency will be completed.** 8-28-21	
K 0311 SS=E Bldg. 01	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of			

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	at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. Based on observation and interview, the facility failed to ensure 1 of 3 stairwells and 1of 1 elevator shafts maintained a one-hour fire rating. LSC 19.3.1.1 Protection of Vertical Openings, states where enclosure is provided, the construction shall have not less than a 1-hour fire resistance rating. This deficient practice could affect 30 residents in two smoke compartments. Findings include: Based on observation with the Maintenance Director on 07/29/21 at 2:43 p.m., above the ceiling tiles of the third-floor south stairwell there was a three-inch hole in the block wall where the fire brick fell out. Also, above the drop ceiling in the first-floor elevator shaft there was an inch gap where the grout was separating. These conditions would not maintain the one-hour fire rating. Based on interview at the time of observation, Maintenance Director agreed there were unsealed penetrations in a one-hour stairwell and elevator shaft. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0311	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. K311 Vertical Openings-Enclosure · **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Maintenance director filled in hole in the block wall with fire block and fire caulk to ensure there is no gap present. · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected Maintenance Director conducted audit to ensure thee ere no other gaps were present · **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Maintenance Director or	08/28/2021

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			designee will audit the drop ceiling in the first-floor elevator shaft and documentation completed · **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Ongoing compliance with this corrective action will be monitored through the facility QAPI Program, with meetings being held monthly and overseen by the Executive director. The Executive Director or designee will document their findings on the Team "QAPI Tool" weekly for 4 weeks, monthly for 3 months, and quarterly thereafter to ensure the policy/procedures are followed per facility policy. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow up. · **by what date the systemic changes for each deficiency will be completed.** 8-28-21	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in			

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	accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 2 hazardous rooms on the service hall that contained fuel fired equipment were separated from other spaces by smoke resistant partitions. This deficient practice could affect 20 residents in one smoke compartment Findings include: Based on observation with the Maintenance Director on 07/29/21 at 1:10 p.m., in the main mechanical room with fuel fired hot water heaters	K 0321	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. K321 Hazardous Areas- Enclosure · **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Maintenance director sealed	08/28/2021

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	contained an unsealed one-inch gap around the water heater vent. Based on interview at the time of the observation, the Maintenance Director agreed there were unsealed penetration in the mechanical room due to the fire caulk falling from the gap around the vent. The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		penetration with fire caulk to ensure there is no gap around the water heater vent. · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected Maintenance Director conducted audit to ensure there were no other gaps around the water heater. · **what measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** The Maintenance Director or designee will audit the mechanical room water heater to ensure there is no gap present and will document findings. · **how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Ongoing compliance with this corrective action will be monitored through the facility QAPI Program, with meetings being held monthly and overseen by the Executive director. The Executive Director or designee will document their findings on the Team "QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Tool" weekly for 4 weeks, monthly for 3 months, and quarterly thereafter to ensure the policy/procedures are followed per facility policy. If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow up. · **by what date the systemic changes for each deficiency will be completed.** 8-28-21	
K 0331 SS=F Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ Based on observation, records review, and interview, the facility failed to ensure materials used as an interior finish on corridor walls on 3 of 3 floors met the flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 101 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the	K 0331	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. K331 Interior Wall and Ceiling Finish · **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	08/28/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	07/29/2021

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	following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect all residents in the building. Findings include: Based on observation with the Maintenance Director on 07/29/21 between 11:00 a.m. and 2:00 p.m., in all halls on all three floors the corridor walls were either covered with vinyl paneling or carpet on the lower 1/4th of the walls. Based on records review at 10:00 a.m., no documentation of the flame spared rating for the wall coverings was available for review. Based on interview at the time of each observation, the Maintenance Director stated there is flame spread documentation, but it was misplaced by the previous Maintenance Director and has been unable to locate the documentation. This finding was reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		**practice;** Facility requesting temporary construction waiver and will remove the vineer material and replace it with a rated material. We will install Palladium rigid vinyl sheet or like material; spec sheet attached. · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** Executive Director and Maintenance Director toured facility to identify all areas that have the wood look vineer product mounted on the corridor walls from the floor to handrails. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Executive Director/Designee and Maintenance Director/Designee will review any future interior corridor finish materials have the appropriate documentation for a flame spread classification. · **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** Fire QA tool will be utilized weekly x 4, monthly x 3, and quarterly x	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			4. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director/Designee. If threshold is not achieved, an action plan will be developed to ensure compliance. · **What date the systemic changes for each deficiency will be completed** 8/28/21	
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors. This deficient practice	K 0341	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. K341 Fire Alarm System - Installation · **what corrective action(s) will be accomplished for those residents found to have been**	08/28/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN 46992

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	could affect 20 residents on the second floor. Findings include: Based on observation with the Maintenance Director on 07/29/21 at 12:55 p.m., in the second-floor elevator lobby there was a smoke detector next to an air supply where air flow would prevent proper operation of the detector. The detector was about 12 inches from the vent. Based on interview at the time of observation, the Maintenance Director agreed the smoke detector was in the direct airflow from the supply and was within 12 inches of the vent. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		**affected by the deficient practice;** Maintenance Director moved smoke detector 3 feet away from the vent. · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected Maintenance Director measured all smoke detectors near vents to ensure the proper distance. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director or designee will audit area to ensure smoke detector don't get moved and stay within 12 inches of the vent. · **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** QA tool will be utilized weekly x 4, monthly x 3, and quarterly x 4. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director/Designee. If threshold is not achieved, an action plan will be developed to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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			compliance. · **What date the systemic changes for each deficiency will be completed** 8-28-21	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) #1. Based on observation and interview, the facility failed to ensure only one type of sprinkler head i.e. quick response or standard sprinklers were installed in 1 of 2 first floor smoke compartments. NFPA 13, 2010 Edition, Installation of Sprinkler Systems, Section 8.3.3.2 states where quick-response sprinklers are installed, all sprinklers within a compartment shall be quick-response unless otherwise permitted in Section 8.3.3.3 Section 8.3.3.4 states when existing	K 0351	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. K351 Sprinkler System - Installation · **what corrective action(s) will be accomplished for those residents found to have been**	08/28/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN 46992

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	light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a compartmented space shall be changed. This deficient practice could affect up to 10 residents in 1 smoke compartments. Findings include: Based on observation with the Maintenance Director on 07/29/21 at 12:35 p.m., the first-floor dining/lobby smoke compart contained both quick response and standard response sprinkler heads. Based on an interview at the time of observations the Maintenance Director agreed there are mixed response sprinkler heads in the building and stated the facility is in the process of getting quotes to replace the standard response sprinkler heads and did provide documentation of two quotes. #2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler system piping was not used to support Non-System Components accordance with NFPA 13, 2010 edition, Section 9.1.1.7 Support of Non-System Components. Sprinkler piping or hangers shall not be used to support non-system components. This deficient practice could affect 20 residents on the third floor. Findings include: Based on observation with the Maintenance Director on 07/29/21 at 2:29 p.m., above the ceiling tiles by the third-floor elevator there were wires and conduits laying on top of the sprinkler pipes. Based on interview at the time of observation, the Maintenance Director agreed wires and conduits were laying on a sprinkler pipe on the third floor.		**affected by the deficient practice;** Maintenance Director moved wires and conduit from pipe · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected Maintenance Director audited all smoke compartments to ensure there were no wires or conduit laid on any pipes. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director or designee will audit area to ensure wires and conduit are not get laid on pipe again · **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** QA tool will be utilized weekly x 4, monthly x 3, and quarterly x 4. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director/Designee. If threshold is not achieved, an action plan will be developed to ensure compliance.	

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	155162	A. BUILDING 01 B. WING	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		· **What date the systemic changes for each deficiency will be completed:** 8-28-21	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 #1. Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 3 stairwells. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects all residents. Findings include:	K 0353	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. K353 Sprinkler System – Maintenance and Testing · **what corrective action(s)**	08/28/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN 46992

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation with the Maintenance Director on 07/29/21 at 1:30 p.m., in the suspended ceiling of the south stairwell there was a ceiling tile with a large hole due to water damage. This condition could delay the activation of the sprinklers installed on the suspended ceiling. Based on interview at the time of the observation, the Maintenance director agreed the ceiling tile contained a large hole. #2. Based on observation and interview, the facility failed to ensure 8 of 50 sprinklers in on the first floor were free of corrosion. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff and up to 10 residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director on 07/29/21 at 12:28 p.m., sprinkler heads in the kitchen and outside of the building by therapy were green and showed signs of corrosion. Based on interview at the time of observation, the Maintenance Director agreed there were sprinkler heads in the building that showed signs of corrosion and stated the facility is in the process of getting quotes to replace the sprinkler heads.		**will be accomplished for those residents found to have been affected by the deficient practice;** Tile was replaced Sprinkler heads on schedule to be replaced · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected Maintenance Director audited facility and replaced ceiling tiles with holes or discolored. Maintenance Director will continue to audit facility for other corroded sprinkler heads and will have replaced as needed. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Maintenance Director will add to TELS monitor system and add to routine maintenance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** QA tool will be utilized weekly x 4, monthly x 3, and quarterly x 4. The results of these audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN RIDGE REHABILITATION CENTRE	600 WASHINGTON AVE WABASH, IN 46992

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	The findings were reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		reviewed by the QAPI committee overseen by the Executive Director/Designee. If threshold is not achieved, an action plan will be developed to ensure compliance. · **What date the systemic changes for each deficiency will be completed:** 8-28-21	
K 0511 SS=F Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 #1 Based on observation and interview, the facility failed to ensure 2 of 40 electrical outlets on the first floor and 1 of 5 electrical outlets in the storage hall contained a cover plate and was protected from damage. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 15 residents in room in on the first and second floors. Findings include: Based on observation with the Maintenance	K 0511	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. K511 Utilities – Gas and electric · **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Maintenance Director replaced faceplates (cover plates). Maintenance Director covered junction boxes with face plate. · **how other residents having the potential to be**	08/28/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Director on 07/29/21 between 12:00 p.m. and 2:00 p.m., in the Business Office and in the service hall there were electrical outlets with missing cover plates. Also, in the storage hall part of an outlet was damage exposing meatal terminals. Based on interview at the time of observation, the Maintenance Director agreed outlets were missing a cover plates, were physically damage, and there were electrical contacts visible. #2 Based on observation, the facility failed to ensure 3 of 3 electrical junction and junction boxes were maintained in a safe operating condition. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 314.28(3) (c) states junction boxes shall be provided with covers compatible with the box and suitable for the conditions of use. Where used, metal covers shall comply with the grounding requirements of 250.110. This deficient practice could affect all residents. Findings include: Based on observation with the Maintenance Director on 07/29/21 between 2:00 p.m. and 3:00 p.m., above the celling tiles by the elevator on all three floors there were electrical junctions and junction boxes that that were not properly protected inside of a box or with a cover plate. Based on interview at the time of the observations, the Maintenance Director agreed the electrical junction boxes were not provided with a cover and there were unprotected exposed wires. The findings were reviewed with the Maintenance Director and Administrator during the exit		**affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected Maintenance Director audited facility all face plates and junction boxes were properly covered. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director or designee will audit area to ensure electrical outlets and junction boxes are covered with a face plate · **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** QA tool will be utilized weekly x 4, monthly x 3, and quarterly x 4. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director/Designee. If threshold is not achieved, an action plan will be developed to ensure compliance. · **What date the systemic changes for each deficiency will be completed:** 8-28-21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	07/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	conference. 3.1-19(b)			
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 Based on observation and interview; the facility failed to ensure 1 of 1 smoking areas were maintained by disposing cigarette butts in the provided noncombustible container smokers pole.	K 0741	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local	08/28/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	07/29/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This deficient practice could affect staff that use the service hall exit. Findings include: Based on observation with the Maintenance Director on 07/29/21 at 12:18 p.m., outside of the service hall exit there were 5 cigarette butts on the ground and in the mulch. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground outside of the service hall. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)		laws. K741 – Smoking Regulations · **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Maintenance Director removed the 5 cigarette butts from the ground. · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;** All residents have the potential to be affected Maintenance Director audited facility grounds no other area is a smoke area, no cigarette butts were found in another area of the grounds. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** Staff were educated to dispose of cigarettes in the smoking receptacle only. · **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** QA tool will be utilized weekly x 4, monthly x 3, and quarterly x 4. The results of these audits will be reviewed by the QAPI committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	07/29/2021

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			overseen by the Executive Director/Designee. If threshold is not achieved, an action plan will be developed to ensure compliance. · **What date the systemic changes for each deficiency will be completed:** 8-28-21	
K 0781 SS=E Bldg. 01	NFPA 101 Portable Space Heaters Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 Based on observation and interview; the facility failure to ensure 1 of 1 portable space heaters were not used in resident areas. This deficient practice could affect 10 residents on the first floor. Findings include: Based on observation with the Maintenance Director on 07/29/21 at 12:01 p.m., in the lobby a fireplace containing a space heater was used in a resident area. When tested, the heater did turn on and produced heat. Based on interview at the time of observation the Maintenance Director stated there is a working electric fireplace with a heater in a resident area. This finding was reviewed with the Maintenance Director and Administrator during the exit conference.	K 0781	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. **K 781** Portable Space Heaters · **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Maintenance Director disabled the element that produced heat to the cosmetic fireplace. · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken;**	08/28/2021

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	3.1-19(b)		All residents have the potential to be affected No other cosmetic fireplaces in facility · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director or designee will audit area to ensure the cosmetic fireplace is not producing heat · **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** QA tool will be utilized weekly x 4, monthly x 3, and quarterly x 4. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director/Designee. If threshold is not achieved, an action plan will be developed to ensure compliance. · **What date the systemic changes for each deficiency will be completed:** 8-28-21	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable			

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	patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	#1. Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 5 residents in front office area. Findings include: Based on observation with the Maintenance Director on 07/29/21 at 12:03 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the Business Office, Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was supplying power	K 0920	It is the intent of this provider to have an emergency preparedness communication plan that complies with Federal, State, and local laws. **K 920 Electrical Equipment Power cords And Extens** · **what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Maintenance Director removed power strips identified. · **how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will**	08/28/2021

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	to high power draw equipment. #2. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could staff on the storage hall. Findings include: Based on observation with the Maintenance Director on 07/29/21 at 12:33 p.m., in the Housekeeping office a power strip used to power equipment, was not secured, and was dangling from the outlet on the wall. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the Maintenance Director agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. The findings were reviewed with the Maintenance Director and Administrator during the exit conference. 3.1-19(b)		**be taken;** All residents have the potential to be affected Maintenance Director audited facility to ensue there were no other power strips in use in facility. · **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** The Maintenance Director or designee will audit area to ensure the facility has no other power strips in use · **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** QA tool will be utilized weekly x 4, monthly x 3, and quarterly x 4. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director/Designee. If threshold is not achieved, an action plan will be developed to ensure compliance. · **What date the systemic changes for each deficiency will be completed:** 8-28-21	