	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 10/28/2021		
		155162	B. WING				
			STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIE	R	600 W	ASHINGTON AVE			
AUTUMN	N RIDGE REHABIL	ITATION CENTRE	WABA	SH, IN 46992			
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF	^{BE} RIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
F 0000							
Bldg. 00							
Diug. 00	This visit was for t	the Investigation of Complaint	F 0000	This Plan of Correction con	stitutes		
	IN00363315.	the investigation of complaint	1 0000	the written allegation of	Stitutoo		
				compliance for the deficience	cies		
	Complaint IN0036	5315 - Substantiated.		cited. However, submission			
	-	ciencies related to the		this Plan of Correction is no			
	allegations are cite	ed at F600 and F609.		admission that a deficiency	exists		
	-			or that one was cited correct	tly.		
	Survey dates: Octo	ober 25, 26, 27 and 28, 2021		The Plan of Correction is			
				submitted to meet requirem	ents		
	Facility number: 0	00081		established by state and fee	leral		
	Provider number:	155162		law. Autumn Ridge Rehabi	litation		
	AIM number: 100	289570		Centre desires this Plan of			
				Correction to be considered	the		
	Census Bed Type:			facility's Allegation of			
	SNF/NF: 48			Compliance. We respectfu	ly		
	Total: 48			request paper compliance.			
				Compliance is effective			
	Census Payor Typ	e:		11/18/2021.			
	Medicare: 1						
	Medicaid: 39 Other: 8						
	Total: 48						
	10.001. 70						
	These deficiencies	reflect State Findings cited in					
	accordance with 4						
	Quality review con	mpleted on November 5, 2021.					
F 0600	483.12(a)(1)						
SS=D	Free from Abuse	and Neglect					
Bldg. 00		n from Abuse, Neglect, and					
	Exploitation						
		the right to be free from					
		nisappropriation of resident					
	-	ploitation as defined in this					
		cludes but is not limited to					
		rporal punishment,					
	1					1	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED:

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Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 155162 B. WING 10/28/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE WABASH. IN 46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, interview and record F 0600 **F600** It is the policy of this facility 11/18/2021 review, the facility failed to prevent staff to to prevent the resident from resident abuse for 1 of 1 resident's reviewed for Abuse, Neglect, Misappropriation staff to resident abuse (Resident B). of resident property, and exploitation. Findings include: What corrective action will be accomplished for residents A review of an incident report, dated 10/19/21, affected? The Director of Nursing and indicated at 12:35 p.m., while staff was assisting the Resident B to bed, the resident made a Executive Director were notified negative statement to the MCS (Memory Care by staff who were on-duty at the Support) and the MSC responded in a negative time of the incident. Upon way to the resident. Resident B was monitored by notification, the MCS (Memory social services for 72 hours for signs and Care Support) staff member was symptoms of psycho-social discord. An internal suspended from duty at that time investigation was initiated. MCS was suspended and an investigation was initiated. pending the investigation. A report also went to the Elder Justice system. Resident B's record was reviewed on 10/25/21 at All Staff have been in-serviced on 3:00 p.m. Diagnoses included, but were not Abuse Policy as of 10/21/21. limited to, Alzheimer's disease, dementia in How will the facility identify other diseases classified elsewhere with other residents having the behavioral disturbance and major depressive potential to be affected by the same practice and what disorder, single episode. corrective action will be taken? A quarterly MDS, dated 9/8/21, indicated the All residents in this facility have resident was moderately cognitively impaired. the potential to be affected. Social He required extensive assistance of two staff Services and the Executive

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members for bed mobility, transfers and toileting. Her required extensive assistance of

one staff member for locomotion on and off the

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352511 Facility

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Director conducted interviews with

each resident regarding the care

and services that they receive.

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155162 B. WING 10/28/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE WABASH. IN 46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) unit, dressing and personal hygiene. He required There were no other allegations of a wheelchair. abuse or inappropriate care made as a result of those interviews. The investigation was provided by the DON, on What measures will be put into 10/25/21 at 10:33 a.m., staff and resident were place to ensure this practice interviewed related to the MCS and abuse. does not recur? Inservice for staff on abuse was initiated The Executive Director will be covering abuse definition, examples and policy immediately notified of any and procedure. Investigation was concluded on allegations of abuse. An investigation will be initiated 10/21/21. Upon careful review of all information this allegation was unsubstantiated. The MCS immediately, and the alleged returned to work on 10/22/21. abuser will be suspended from the facility pending the outcome of the investigation. The IDT team will During an interview with the MCS, on 10/25/21 observe staff interactions with at 9:24 a.m., she indicated Resident F was having behaviors, the nurse called her into the room to residents as part of their routine assist. Resident F had already punched a CNA rounds throughout the facility. If twice in face. As they transferred him to the bed any concern arises, the IDT with the stand up lift, he was hitting, scratching member will intercede immediately and punching at them. She held onto his bottom to protect the resident and follow as they transferred him to the bed because she through with notification of the felt that he was going to fall. He had bitten her on Executive Director. Allegations of the forearm, scratched the nurse on the forearm. abuse and investigation activities She indicated to him "We do not act like a five and results will be discussed in the clinical meeting. year old by punching, hitting and kicking." She received abuse training and education after the All staff will be in-serviced on incident. She was suspended from noon on Tuesday and came back to work Friday morning. types of abuse at each monthly This had never happened before and she felt it in-service order to provide was just in the heat of the moment. He had additional education and training behaviors all day and had thrown water on on proper care techniques. Executive Director and Social everyone. Services Director will meet with each resident weekly to discuss During an interview, on 10/25/21 at 2:15 p.m., CNA 17 indicated on 10/19/21, Resident B was their care and address any in the dining room at lunch and throwing things. concern, completing the QIS abuse questions Any concerns He was removed to his room for safety towards will be investigated immediately. other residents and was going to assist him to bed. They used the stand lift to put him to bed as they went to stand him, he (Resident B) refused. How corrective Action(s) will be

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352511

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]	DEPARTMENT OF HEALTH AND HUN	1AN SERVICES	
(CENTERS FOR MEDICARE & MEDICA	AID SERVICES	
[STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155162	A. BUILDING <u>00</u> B. WING				
	PROVIDER OR SUPPLI	ITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE (X5) COMPLETIC DATE		
	He had hit her in the went to go get the on the bed and the He said to the MC turned around and one said anything not hear her say to year old. During a telephon 3:13 p.m., LPN 44 of behaviors, cuss day Resident B w the dining room. I punched a CNA in diffused the situat resident the whole stand lift for him the room the MCS why does Resider 44 did not think the and the television comment but not they were walking had no reaction to saying that he was kind of a jungle ir was cussing and s there. If she said i abuse. A current facility PROHIBITION, I INVESTIGATIO table on 10/26/21 following: "It is the Communities to p including physica abuse, mental abuse.	he jaw a couple times. LPN 44 MCS, all of them assisted him MCS swung his legs into bed. S your being a b***h and she said your being a douche. No else and left the room. She did o him to stop acting like a five e interview, on 10/25/21 at d indicated Resident B had a lot ing and touching the girls. That as cussing and throwing water in He was given ice cream and in the face. The MCS came in a ion and was polite with the etime. She assisted with the etime. She assisted with the o get to bed. On the way out of G indicated quietly to LPN 44 t B have to be a douche. LPN he resident could hear her say it was on. It was an inappropriate owards Resident B, it was as gout of his room. Resident B it. He did not remember her et acting like a 5 year old. It was his room, his bed was wet, he winging and was pretty nuts in t to the resident that would be policy, titled "ABUSE REPORTING, AND N," located on the conference at 1:15 p.m., indicated the he policy of American Senior rotect resident from abuse a buse, sexual abuse, verbal sePOLICY/PROCEDURE: Communities will not permit		monitored to ensure the deficient practice will not re i.e., what quality assurance program will be put into plate - The Executive Director and/or Designee will complete Abuse QAPI tool weekly x4 weeks a monthly for 6 months. If 100% compliance is not achieved a action plan will be implement. The Administrator is response for the implementation and monitoring of this process. Date of compliance: Novemb 18, 2021	ce? r e nd 6 n ed. ble		

AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155162	(X2) MULTIPLE C A. BUILDING B. WING	00		(X3) DATE SURVEY COMPLETED 10/28/2021		
	PROVIDER OR SUPPLIE	R ITATION CENTRE	600 W/	ADDRESS, CITY, STATE, ZI ASHINGTON AVE SH, IN 46992	P CODE			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH	N SHOULD BE	(X5) COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG DEFICIENCY)		· · · · · · · · · · · · · · · · · · ·	DATE		
		jected to abuse by anyone, es, other residents"						
	This Federal Tag 1 IN00365315.	elates to Complaint						
	3.1-27(a)(1) 3.1-27(b)							
F 0609 SS=D Bldg. 00	• • • •	ged Violations ponse to allegations of exploitation, or mistreatment,						
	violations involvin exploitation or m of unknown sour resident property but not later than is made, if the ev allegation involve bodily injury, or n events that cause abuse and do no injury, to the adm to other officials Survey Agency a where state law p long-term care fa	sure that all alleged ng abuse, neglect, istreatment, including injuries ce and misappropriation of a, are reported immediately, 2 hours after the allegation rents that cause the e abuse or result in serious ot later than 24 hours if the e the allegation do not involve t result in serious bodily inistrator of the facility and (including to the State ind adult protective services provides for jurisdiction in cellities) in accordance with in established procedures.						
	investigations to her designated ro officials in accord including to the S 5 working days of	port the results of all the administrator or his or epresentative and to other lance with State law, State Survey Agency, within f the incident, and if the is verified appropriate						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155162				JILDING	00	(X3) DATE SURVEY COMPLETED 10/28/2021	
	PROVIDER OR SUPPLIE N RIDGE REHABIL	R ITATION CENTRE	STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ION D BE OPRIATE	(X5) COMPLETION DATE
	facility failed to er reported immediat for 1 of 7 allegatio Findings include: Review of a 9/3/21 7:55 p.m., Residen Resident F's pants backside. A nurses note, data indicated an aide h Resident G was se indicated she had j bottom. The note i scolded Resident F approached Reside her to get out of th Resident F several to her. Resident F's nurse: a.m., indicated Res on the bottom aggi injuries were noted During an intervie 10/26/21 at 10:45 incident was found and thought they s not reported it to th DON. It happened Labor day, it was n normally report ab hours to the State A	eview and interview, the hsure allegations of abuse was ely to the Executive Director ns of abuse reviewed. It incident report indicated at at G attempted to help pull up and made contact with her ed 9/4/21 at 1:05 a.m., heard a slapping sound and en near Resident F. Resident G for wandering, she ent F with a stern look and told e area and put her hands on times while speaking angrily s note, dated 9/4/21 at 1:27 sident F was apparently struck ressively by Resident G. No d. w with the Administrator, on a.m., she indicated the d while doing a clinical review hould report it. The nurse had he Executive Director or on Friday 9/3/21, 9/6/21 was reported on 9/7/21. They would use allegations within 24	FO	509	F609 It is the policy of Aut Ridge Rehabilitation Centr report all allegations/abus Executive Director immed and that the Executive Dir report to the Indiana Depa of Health any allegation of exploitation, mistreatment of unknown source, or misappropriation of reside property to the Indiana Sta Department of Health with hours from allegation. All of that do not involve abuse serious bodily injury are to reported within 24 hours of occurrence to ISDH. What corrective action w accomplished for resider affected? One resident was found to affected by this alleged de practice. Resident F did me experience any injury All resident allegations of neglect, and exploitation of residents or misappropriat residents or misappropriat resident property will be re- to Administrator immediate allegations of abuse will b submitted to ISDH within 2 as required. All allegations abuse will be investigated notification of incident. How will the facility ident other residents having the potential to be affected by same practice and what corrective action will be	re to e to the iately ector will intment f abuse, , injury nt ate in 2 events or be f ill be its be f ill be its be f icient ot abuse, of eported ely. All e 2 hours s of following ify he y the	11/18/2023

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION 2	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155162	B. WING		10/28/2021		
NAME OF	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP CODE			
				ASHINGTON AVE			
AUTUM	N RIDGE REHABIL	ITATION CENTRE	WABA	SH, IN 46992			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	PROHIBITION, R	EPORTING, AND		All residents in this facility have			
		I," located on the conference		the potential to be affected. Soc	ial		
		at 1:15 p.m., indicated the		Services and the Executive			
	-	CY/PROCEDURE:5. All		Director conducted interviews w			
	•	buse must be reported to the		each resident regarding the care	e		
		r immediately, and to the		and services that they receive.			
	-	tative (sponsor, responsible		There were no other allegations			
		burs of the report7. The		abuse or inappropriate care ma	de		
		r/designee will report all		as a result of those interviews.	1		
		es, which include abuse, within		Staff education has been provid	ea		
		ery, to the Long Term liana State Department of		regarding abuse and timely reporting of abuse to the ED.			
	Health.	nana State Department of		What measures will be put into			
	ricalul.			place to ensure this practice	,		
	This Federal Tag r	elates to Complaint		does not recur?			
	IN00365315.	clates to complaint		The Executive Director will be			
	1100505515.			immediately notified of any			
	3.1-28(c)			allegations of abuse and will			
				ensure that the notification will b	e		
				made to the state agency within			
				hours of being notified of that			
				alleged abuse. An investigation	will		
				be initiated immediately.			
				ED/Designee will review the dai	ly		
				activitiy report to ensure any			
				allegation of abuse was reported	b		
				immediately.			
				ED/Designee inserviced staff or	1		
				10/27/21 about reporting			
				requirements of abuse to the EI)		
				immediately.			
				How corrective Action(s) will b	e		
				monitored to ensure the			
				deficient practice will not recu	,		
				i.e., what quality assurance program will be put into place	,		
				The ED/Designee will complete			
				Abuse Reporting QAPI tool wee			
				x4 weeks and monthly for 6	ixiy		
				months. If 100% compliance is			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 155162 B. WING							PRINTED: 11/22/202 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
155162 NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE			B. WI	B. WING 10/28/202 STREET ADDRESS, CITY, STATE, ZIP CODE 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMF	(X5) PLETION ATE
			not achieved an action plan will be implemented. The Executive Director is responsible for the implementation and monitoring of this process. Date of Compliance: November 18, 2021					

352511 Facility ID: 000081

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