STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 00 B. WING	01/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0000 Bldg. 00	This visit was for a COVID-19 Focused Infection Control Survey. Survey dates: January 24 and January 25, 2022 Facility number: 000081 Provider number: 155162 AIM number: 100289570 Census Bed Type: SNF/NF: 48 Total: 48 Census Payor Type: Medicare: 2 Medicaid: 35 Other: 11 Total: 48 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 28, 2022.	F 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by state and federal law. Autumn Ridge Rehabilitation Centre desires this Plan of Correction to be considered the facility's Allegation of Compliance. We respectfully request paper compliance. Compliance is effective 2.16.2022.	
F 0886 SS=D Bldg. 00	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 00 B. WING	01/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 00 B. WING	01/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.			
	Based on interviews and record review, the facility failed to properly prevent and/or contain COVID-19 by failing to ensure employees were tested according to the Indiana Department of Health (IDOH) and the Centers for Disease Control and Prevention (CDC) guidance for COVID-19 for 2 of 5 employees reviewed for COVID testing (Laundry Aide 9 and QMA 10). Findings include: 1. Employee COVID-19 test results, provided by the Administrator on 1/24/22 at 11:55 a.m., were reviewed, on 1/25/22 at 10:33 a.m., and indicated Laundry Aide 9 was tested for COVID-19 on 1/06/22, 1/13/22 and 1/17/22. According to the current employee vaccination status list provided by the Administrator, on 1/24/22 at 11:48 a.m., Laundry Aide 9 was not vaccinated for COVID-19. During an interview, on 1/25/21 at 12:41 p.m., the Administrator indicated Laundry Aide 9 tested negative for COVID-19 today (1/25/22).	F 0886	**F 886** What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected. 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 if they were to come into contact with one or both of the employees that missed testing. Testing of staff not fully vaccinated will be done following the ISDH and CDC guidelines. Any staff that is not fully vaccinated will be tested following the IDOH and CDC guidelines determined by the county	02/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 00 B. WING	01/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	She indicated the COVID-19 testing paperwork and spreadsheet was rechecked. She spoke with Laundry Aide 9. She indicated no additional COVID-19 testing was completed. She indicated Laundry Aide 9 worked during the period from 1/06/22 to 1/25/22. 2. Employee COVID-19 test results, provided by the Administrator on 1/24/22 at 11:55 a.m., were reviewed, on 1/25/22 at 10:33 a.m., and indicated QMA 10 was tested for COVID-19 on 1/06/22 and 1/13/22. According to the current employee vaccination status list provided by the Administrator, on 1/24/22 at 11:48 a.m., QMA 10 was not vaccinated for COVID-19. During an interview, on 1/25/21 at 12:41 p.m., the Administrator indicated she rechecked the COVID-19 testing paperwork and spreadsheet. She indicated she was unable to locate additional COVID-19 testing documentation for QMA 10. She indicated QMA 10 worked during the period from 1/13/22 to 1/23/22. During an interview, on 1/25/21 at 1:11 p.m., the Administrator indicated the Payroll Coordinator performed COVID-19 testing of staff on Tuesdays and Fridays. She indicated no process was currently in place for following up on employees who failed to test as required. Review of a current facility policy titled "COVID Testing Requirements for Staff and Residents" revised on 11/29/21 and provided by the Administrator on 1/24/22 at 11:48 a.m., indicated the following: " ... Routine testing of unvaccinated staff should be based on community transmission ... Facilities should use their community transmission level reported in the past week, found on the CDC website, as a		transmission rate for the week prior. Unvaccinated staff will be in-serviced on the requirements for testing on February 10,2022 by the IP nurse. The IP nurse will bring the list of tests to the morning meeting to be reviewed to ensure that all unvaccinated staff are being tested twice weekly during a high transmission rate. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; All unvaccinated staff will be in-serviced by IP on the requirements of testing. The IP nurse will bring the list of tests to the morning meeting to be reviewed to ensure that all unvaccinated staff are being tested twice weekly during a high transmission rate. Any staff member not having two test weekly will be removed from the schedule until both test are completed. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, what quality assurance program will be put into place; Ongoing compliance with this corrective action will be monitored via facility QAPI program, with	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 00 B. WING	01/25/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
	trigger for staff testing frequency ..." "Table 2: Routine Testing Intervals by County COVID-19 Level of Community Transmission" in the current policy indicated minimum testing frequency of unvaccinated staff for a county transmission level of high (red) was twice a week. Review of the CDC COVID Data tracker website (https://covid.cdc.gov/covid-data-tracker/#datatracker-home), on 1/25/21 at 1:25 p.m., indicated level of community transmission for Wabash County was high (red) from 12/27/21 through 1/25/22. Review of an Indiana Department of Health resource document, retrieved from the IDOH Long Term Care newsletter dated 11/24/21, titled LTC COVID-19 SOP Guidance, Clinical Guidance, last updated 11/22/21 indicated, "...The facility should test all unvaccinated staff at the frequency prescribed in the Routine Testing table based on the level of community transmission reported in the past week..." The Routine Testing table indicated the minimum testing of unvaccinated staff is twice a week when the level of COVID-19 community transmission is high (red). 3.1-18(b)		meetings being held monthly, and is overseen by the Executive Director. The IP nurse will report to the QAPI Committee monthly results of the unvaccinated staff testing until compliance is achieved. If Threshold of 100% is not met, an action plan will be developed to ensure compliance.	