	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		NSTRUCTION	(X3) DATE SURVEY  COMPLETED  07/19/2022	
	PROVIDER OR SUPPLIER		•	600 WA	ADDRESS, CITY, STATE, ZIP COD SHINGTON AVE SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E 0000							
Bldg	conducted by the In accordance with 42  Survey Date: 7/19/2  Facility Number: 0  Provider Number: 1002  At this Emergency I Ridge Rehabilitation compliance with En Requirements for M Participating Provide	22 200081 155162 289570 Preparedness survey, Autumn a Centre was found not in nergency Preparedness dedicare and Medicaid ters and Suppliers, 42 CFR has a capacity of 75 and had a time of this survey.	E 0	000			
E 0039 SS=F Bldg	441.184(d)(2), 482 483.73(d)(2), 484. 485.68(d)(2), 485. 486.360(d)(2), 497 EP Testing Requir §416.54(d)(2), §47 §460.84(d)(2), §47 §483.475(d)(2), §47 §485.625(d)(2), §47 (2), §491.12(d)(2), *[For ASCs at §41 OPO, "Organizatio CMHCs at §485.9	8.113(d)(2), §441.184(d)(2), 32.15(d)(2), §483.73(d)(2), 84.102(d)(2), §485.68(d)(2), 85.727(d)(2), §485.920(d)					

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

(X6) DATE

TITLE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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.

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  07/19/2022	
	PROVIDER OR SUPPLIEI		6	00 WAS	DDRESS, CITY, STATE, ZIP COD SHINGTON AVE H, IN 46992		
(X4) ID		STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	ICY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCIT		DATE
	. ,	facility] must conduct he emergency plan					
		cility] must do all of the					
	following:	siity] must do aii oi trie					
		full-scale exercise that is					
	•	l every 2 years; or					
	` '	nunity-based exercise is anduct a facility-based					
		-					
functional exercise every 2 years; or  (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required							
	community-based or individual, facility-based						
		e following the onset of the					
	actual event.						
	` '	Iditional exercise at least		1			
		posite the year the full-scale					
		cise under paragraph (d)(2)					
	1 ' '	s conducted, that may limited to the following:					
		scale exercise that is		1			
	1 ' '	or individual, facility-based					
	functional exercis	-					
	(B) A mock disast						
	` '	ercise or workshop that is					
		and includes a group					
	discussion using	a narrated,					
	-	emergency scenario, and a					
	set of problem sta						
		pared questions designed					
	to challenge an e						
		acility's] response to and					
		ntation of all drills, tabletop nergency events, and revise					
		rgency events, and revise					
	ine fracility of either	rigorioy pian, as needed.					
	*[For Hospices at	418.113(d):]					
	-	espices that provide care in					

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	PARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION G	N	(X3) DATE SURVEY  COMPLETED  07/19/2022			
NAME OF	PROVIDER OR SUPPLIE	3		EET ADDRESS, CIT WASHINGTO	TY, STATE, ZIP COD ON AVE				
AUTUM	N RIDGE REHABIL	TATION CENTRE	WA	BASH, IN 4699	92				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION	ID PREF	X (EACH CO CROSS-REF	VIDER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRI DEFICIENCY)	IATE	(X5) COMPLETION DATE		
IAU	the patient's home conduct exercises plan at least annuathe following: (i) Participate in a community based (A) When a commaccessible, condubased functional (B) If the hospice man-made emergor of the emergency exempt from engascale community-facility-based functional exercis of this section is of include, but is not (A) A second full-community-based functional exercis (B) A mock disass (C) A tabletop exelled by a facilitator discussion using a clinically-relevant set of problem stamessages, or preto challenge an exercises to test to	e. The hospice must is to test the emergency stally. The hospice must do a full-scale exercise that is every 2 years; or nunity based exercise is not act an individual facility exercise every 2 years; or experiences a natural or lency that requires activation plan, the hospital is aging in its next required full based exercise or individual ctional exercise following the gency event. Inditional exercise every 2 le year the full-scale or e under paragraph (d)(2)(i) conducted, that may limited to the following: escale exercise that is a or a facility based e; or ter drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a stements, directed pared questions designed					DATE		

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(i) Participate in an annual full-scale exercise

(A) When a community-based exercise is not

that is community-based; or

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	IENT OF DEFICIENCIES  AN OF CORRECTION	IDENTIFICATION NUMBER  155162		ILDING	NSTRUCTION	COMPL 07/19/	ETED	
	F PROVIDER OR SUPPLIEI  MN RIDGE REHABILI		STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	facility-based fund (B) If the hospice man-made emerg of the emergency exempt from enga full-scale commun functional exercis emergency event (ii) Conduct an act that may include, following: (A) A second full- community-based functional exercis (B) A mock disas (C) A tabletop ex facilitator that incl using a narrated, emergency scena statements, direct questions designe emergency plan. (iii) Analyze the h maintain documen exercises, and en the hospice's eme  *[For PRFTs at §4 §482.15(d), CAHs (2) Testing. The [I conduct exercises plan twice per yea CAH] must do the (i) Participate in a that is community (A) When a comm accessible, condu	dditional annual exercise but is not limited to the  -scale exercise that is I or a facility based e; or ster drill; or ercise or workshop led by a udes a group discussion clinically-relevant ario, and a set of problem sted messages, or prepared ed to challenge an  nospice's response to and intation of all drills, tabletop inergency events and revise ergency plan, as needed.  441.184(d), Hospitals at is at §485.625(d):] PRTF, Hospital, CAH] must is to test the emergency ar. The [PRTF, Hospital, e following: an annual full-scale exercise						

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	R MEDICARE & MEDIC	CAID SERVICES				OKM APPROVED OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION	COM	ie survey ipleted 19/2022
	PROVIDER OR SUPPLIE	R ITATION CENTRE	600 W	TADDRESS, CITY, STATE, ZIP CO VASHINGTON AVE ASH, IN 46992	)D	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	an actual natural that requires active plan, the [facility] its next required for individual, facilifollowing the onse (ii) Conduct exercise or and the limited to the following the onse facility-based function (B) A monotonic (C) A tabletowise led by a facilitate discussion, using clinically-relevant set of problem stands and maintain doctabletop exercise and revise the [faneeded.  *[For PACE at §4 (2) Testing. The face conduct exercises plan at least annorganization mus (i) Participate in a that is community (A) When a community (A) When a community conduct exercisely accessible, conducted in a community (A) When a community (A) w	-scale exercise that is d or individual, a ctional exercise; or ock disaster drill; or p exercise or workshop that tor and includes a group a narrated, emergency scenario, and a atements, directed spared questions designed mergency plan. The [facility's] response to umentation of all drills, s, and emergency events cility's] emergency plan, as  60.84(d):]  PACE organization must s to test the emergency ually. The PACE t do the following: an annual full-scale exercise				
		ctional exercise; or xperiences an actual natural				

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or man-made emergency that requires activation of the emergency plan, the PACE

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<del></del>	COMPL	ETED	
		155162	B. W	ING		07/19/	/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	R			SHINGTON AVE			
AUTUMN	N RIDGE REHABILI	TATION CENTRE			6H, IN 46992			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCEN AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE	
	is exempt from en	gaging in its next required						
	full-scale commur	nity based or individual,						
	facility-based functional exercise following the							
	onset of the emer	gency event.						
	(ii) Conduct a	n additional exercise every						
		he year the full-scale or						
		e under paragraph (d)(2)(i)						
		onducted that may include,						
	but is not limited t	•						
	` '	scale exercise that is						
	_	or individual, a facility						
	based functional exercise; or							
	(B) A mock disas							
	. ,	ercise or workshop that is						
	discussion, using	and includes a group						
		emergency scenario, and a						
	set of problem sta	-						
		pared questions designed						
	to challenge an er	·						
	_	PACE's response to and						
		ntation of all drills, tabletop						
		nergency events and revise						
		gency plan, as needed.						
	*[For LTC Facilitie	. , -						
		ty] must conduct exercises						
	_	ency plan at least twice per						
		announced staff drills using						
		ocedures. The [LTC facility,						
	ICF/IID] must do t	•						
		nn annual full-scale exercise						
	that is community							
	, ,	nunity-based exercise is not						
	· ·	ct an annual individual,						
	facility-based functional exercise.  (B) If the [LTC facility] facility experiences an							
	. ,							
		nan-made emergency that n of the emergency plan, the						
	-	mpt from engaging its next						
		mpi nom engaging its next	1					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155162	B. W	ING		07/19/	/2022
NAME OF I	PROVIDER OR SUPPLIEF	}			ADDRESS, CITY, STATE, ZIP COD		
					ASHINGTON AVE		
AUTUMN	N RIDGE REHABILI	TATION CENTRE		WABAS	SH, IN 46992		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	i e	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
		lle community-based or					
		based functional exercise					
	-	et of the emergency event.					
		dditional annual exercise					
	_	but is not limited to the					
	following:	scale eversion that is					
		scale exercise that is or an individual, facility					
	based functional	<del>_</del>					
	(B) A mock disas	•					
	` '	ercise or workshop that is					
	led by a facilitator	· · · · · · · · · · · · · · · · · · ·					
	discussion, using	- · · · · · · · · · · · · · · · · · · ·					
		emergency scenario, and a					
	set of problem sta	•					
	1	pared questions designed					
	to challenge an er						
		LTC facility] facility's					
		naintain documentation of					
	all drills, tabletop	exercises, and emergency					
	events, and revise	e the [LTC facility] facility's					
	emergency plan, a	as needed.					
	*[For ICF/IIDs at §	\$483 475(d)]·					
	-	CF/IID must conduct					
		he emergency plan at least					
		ie ICF/IID must do the					
	following:	ie iei iiie iiie iiie					
		n annual full-scale exercise					
	that is community						
		nunity-based exercise is not					
		ıct an annual individual,					
	· ·	ctional exercise; or.					
	· ·	experiences an actual					
	1 ' '	ade emergency that requires					
		mergency plan, the ICF/IID					
		gaging in its next required					
	full-scale commur	nity-based or individual,					
	facility-based fund	ctional exercise following the					
	onset of the emer	gency event.					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	COM	TE SURVEY MPLETED 19/2022			
	PROVIDER OR SUPPLIEI		600 W	STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE			
	(ii) Conduct an ad that may include, following: (A) A second full-community-based facility-based fund (B) A mock disast (C) A tabletop exeled by a facilitator discussion, using clinically-relevant set of problem stamessages, or preto challenge an el (iii) Analyze the IC maintain documel exercises, and enthe ICF/IID's eme  *[For HHAs at §48 (d)(2) Testing. The exercises to test to least annually. The following: (i) Participate in a community-based (A) When a cois not accessible, individual, facility-every 2 years; or. (B) If the HH natural or man-material or man-materi	ditional annual exercise but is not limited to the scale exercise that is or an individual, ctional exercise; or er drill; or ercise or workshop that is and includes a group a narrated, emergency scenario, and a atements, directed pared questions designed mergency plan. CF/IID's response to and ntation of all drills, tabletop nergency events, and revise rgency plan, as needed.  34.102] e HHA must conduct the emergency plan at e HHA must do the full-scale exercise that is c; or ommunity-based exercise conduct an annual based functional exercise  A experiences an actual adde emergency plan, the HHA is aging in its next required nity-based or individual, ctional exercise following the							

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	ENT OF DEFICIENCIES  N OF CORRECTION	IDENTIFICATION NUMBER  155162	 JILDING	NSTRUCTION	COMPL 07/19/	ETED
	F PROVIDER OR SUPPLIER		600 WA	DDRESS, CITY, STATE, ZIP COD SHINGTON AVE		
AUTUN	IN RIDGE REHABILI	TATION CENTRE	 WABAS	H, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAG	of this section is of include, but is not (A) A second community-based facility-based funcing (B) A mock d (C) A tabletong is led by a facilitat discussion, using clinically-relevant set of problem statemessages, or preto challenge an ere (iii) Analyze the Homaintain documer exercises, and enter the HHA's emerged *[For OPOs at §44 (d)(2) Testing. The exercises to test to OPO must do the (i) Conduct a paper or workshop at lease exercise is led by group discussion, relevant emergen problem statement prepared question emergency plan. If actual natural or not requires activation OPO is exempt for required testing exercises, and emergency (ii) Analyze the Olimaintain documer exercises, and emergency and communication documer exercises, and emergency actual matural or maintain documer exercises, and emergency (iii) Analyze the Olimaintain documer exercises, and emergency actual emergency (iii) Analyze the Olimaintain documer exercises, and emergency actual emergency (iii) Analyze the Olimaintain documer exercises, and emergency (iiii) Analyze the Olimaintain documer exercises, and emergency (iiiii) Analyze the Olimaintain documer exercises, and emergency (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	limited to the following: full-scale exercise that is or an individual, stional exercise; or isaster drill; or o exercise or workshop that or and includes a group a narrated, emergency scenario, and a tements, directed orared questions designed mergency plan. HA's response to and intation of all drills, tabletop inergency events, and revise ency plan, as needed.  36.360] e OPO must conduct the emergency plan. The following: er-based, tabletop exercise ast annually. A tabletop a facilitator and includes a using a narrated, clinically cry scenario, and a set of its, directed messages, or as designed to challenge an of the OPO experiences an man-made emergency plan, the om engaging in its next exercise following the onset	IAG	Esta Nella N		DATE

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Event ID:

GJRK21 Facility ID: 000081

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		lì í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	<del></del>	COMPL	
		155162	B. Wl	NG		07/19/	2022
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	exercises to test till RNHCI must do till (i) Conduct a paperat least annually, group discussion in narrated, clinically scenario, and a sed directed message designed to challe (ii) Analyze the Rimaintain documer exercises, and enter the RNHCI's emel Based on record revision failed to conduct explan at least twice punannounced staff of procedures. The LT following:  (i) Participate in an is community-based a. When a community-based a. When a community-based function in the emergency plan from engaging its in community-based of the emergency plan and the onset of the actual (ii) Conduct an add include, but is not lia. A second full-scale functional and a second full-scale functional and as second full-scale functional and all second full-scale functional and full-scale full-scale functional and full-scale fu	e RNHCI must conduct the emergency plan. The ne following: er-based, tabletop exercise is a led by a facilitator, using a relevant emergency et of problem statements, so, or prepared questions ange an emergency plan. NHCI's response to and natation of all tabletop nergency events, and revise regency plan, as needed. We will an interview, the facility tercises to test the emergency er year, including drills using the emergency experiences an actual natural gency that requires activation lan, the LTC facility is exempt ext required full-scale in a per individual, facility-based all exercise for 1 year following that exercise that may simited to the following: the exercise that is or an individual, facility-based	E 00	039	It is the intent of this facility the the facility will conduct exercise to test the emergency plan at least annually. This will includ full-scale community-based exercise as well as the tableto exercise.  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The required annual testing we conducted, and appropriate documentation will be comple with each exercise.  How other residents having potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken; All dependent residents have	ses e a op II n ill be ted the se	08/17/2022

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE C A. BUILDING B. WING	construction 	(X3) DATE COMPL 07/19	ETED
	PROVIDER OR SUPPLIEI N RIDGE REHABILI		600 W	ADDRESS, CITY, STATE, ZIP CO ASHINGTON AVE SH, IN 46992	OD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
	facilitator that inclusion a narrated, clinically and a set of probler messages, or preparable the challenge and emerging (iii) Analyze the LT maintain document exercises, and emer LTC facility's emergacordance with 42 deficient practice of Findings include:  Based on record regard the Maintenance p.m., there was doc for 2022, but docur annual exercise of a not available for retime of records revet the facility did do a of 2022 but could research.	ation of all drills, tabletop regency events, and revise the regency plan, as needed in CFR 483.73(d)(2). This could affect all occupants.  Wiew with the Administrator representation of an additional choice within the last year was view. Based on interview at the few, the Administrator stated atabletop exercise in February retrieved with the Administrator.		potential to be affected deficient practice. The facility conducted a exercise 8/8/22. What measures will be place and what syster changes will be made ensure that the deficie practice does not recurrent the Maintenance Supe designee will formulate (using the TELS facility maintenance software) the required exercises completed timely. The Executive Director will review all Emergen Preparedness docume ensure it has been compafter each emergency of the term of the deficient practice will recur, i.e., what quality assurance program with into place; and On going compliance we corrective action will be via facility QAPI programeetings being held meaning be	a Tabletop  e put into mic to ent ur; ervisor or a schedule or preventive in which will be or/designee acy ntation to expleted fully exercise.  tion(s) nsure the not y ill be put with this e monitored am, with onthly, and cutive  redness QAPI tool kly x 4 enths, and til d.	

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	OF CORRECTION	IDENTIFICATION NUMBER  155162	A. BUILDING B. WING		COMPLETED 07/19/2022			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, IN 46992					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
				action plan will be developed ensure compliance. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable P of Correction, if it is determined that the correct will not be completed by the date previously submitted, Division needs to be contact as soon as possible. The fa will need to submit an amended plan of correction with the updated plan of correction date. 8/17/22	/ lan ion e The cted cility			
K 0000 Bldg. 01								
	Licensure Survey w Department of Healt 483.90(a).  Survey Date: 07/19  Facility Number: 00 Provider Number: 1 AIM Number: 1002  At this Life Safety C Rehabilitation Centr with Requirements t Medicare/Medicaid, Life Safety from Fir National Fire Protect Life Safety Code (L	00081 155162 289570 Code survey, Autumn Ridge re was found not in compliance	K 0000					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155162		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       01       COMPLETED         B. WING       07/19/2022			ETED		
	PROVIDER OR SUPPLIER		•	600 WA	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K 0222 SS=E Bldg. 01	Type II (111) const sprinklered. The fact with smoke detection the corridor and har resident rooms and had battery operate has a capacity of 75 time of this survey.  All areas where the access were sprinkly facility services were detached sheds used parts.  Quality Review construction of the construction of this survey.  NFPA 101 Egress Doors Egress Doors Doors in a require be equipped with requires the use of egress side unless special locking and CLINICAL NEEDS LOCKING Where special locking and CLINICAL NEEDS LOCKING Where special locking and CLINICAL NEEDS LOCKING where special locking and clinical security nearly only one lock only one lock or keys carrother such reliable staff at all times.	d means of egress shall not a latch or a lock that of a tool or key from the susing one of the following rangements:  S OR SECURITY THREAT  king arrangements for the eeds of the patient are cking device shall be a door and provisions shall apid removal of occupants of locks; keying of all ted by staff at all times; or emeans available to the calcalcalcalcalcalcalcalcalcalcalcalcalc					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155162		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 07/19/2022	
	PROVIDER OR SUPPLIER		600 W	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE COMPLETION OPRIATE
	REGULATORY OR SPECIAL NEEDS ARRANGEMENTS Where special loc safety needs of th the Clinical or Sec are being met. In a electrical locks that release upon loss building is protecte automatic sprinkle space is protected detection system at an attended loc space); and both t systems are arran upon activation. 18.2.2.2.5.2, 19.2. DELAYED-EGRE ARRANGEMENTS Approved, listed d systems installed 7.2.1.6.1 shall be assemblies servin contents in buildin an approved, supe	LISC IDENTIFYING INFORMATION  LOCKING  Sking arrangements for the epatient are used, all of surity Locking requirements addition, the locks must be at fail safely so as to of power to the device; the ed by a supervised or system and the locked or is constantly monitored ation within the locked he sprinkler and detection ged to unlock the doors  2.2.5.2, TIA 12-4 SS LOCKING Selayed-egress locking in accordance with permitted on door golow and ordinary hazard gs protected throughout by ervised automatic fire or an approved, supervised		(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION
		OLLED EGRESS			
	be permitted. 18.2.2.2.4, 19.2.2. ELEVATOR LOBE LOCKING ARRAN Elevator lobby exi accordance with 7 on door assemblie	2.4 BY EXIT ACCESS			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  01		(X3) DATE SURVEY COMPLETED	
		155162	B. WI	ING		07/19/2022
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	automatic fire dete approved, supervi system.  18.2.2.2.4, 19.2.2. Based on observation failed to ensure 1 of was of proper size a (4) states a readily was not less than 1 in. (2 1/8 in. (3.2mm) in sbackground that read on the door leaf adjute direction of egro SOUNDS. DOOR (SECONDS".  This deficient pract storage hall.  Findings include:  Based on observation with the Maintenand 12:15 p.m., the stain hall was provided was the signage indication 15 seconds by pure hard to read, was long not on the door. Base observation, the Maintenand acknowledged the delayed egress and	ection system and an seed automatic sprinkler  2.4  on and interview, the facility of 1 delayed egress locks signs and location. LSC 7.2.1.6.1.(3) visible, durable sign in letters 2.5mm) high and not less than stroke width on a contrasting and as follows shall be located accent to the release device in less: "PUSH UNTIL ALARM CAN BE OPENED IN 15  ice could affect staff on the could affect staff on the long during tour of the facility on the storage with a delayed egress lock, but any the door could be opened ashing the door was too small, cated above the keypad, and seed on interview at the time of a lacked the proper signage.	K 0.		It is the intent of this provider maintain compliance with the regulations for means of egreincluding doors not have a loc that requires the use of a use tool or key from the egress side what corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The sign located on the stair of located in the storage hall has been changed. How other residents having potential to be affected by the same deficient practice will identified and what corrective action(s) will be taken; All residents have the potential be affected by this deficient practice. What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur; The Maintenance Supervisor designee will complete an in-house audit of all egress do to ensure further compliance.  How the corrective action(s) will be monitored to ensure deficient practice will not	to 08/17/2022 sss, sk a de.  II n door sthe ne be re all to nto or pors
			I		uencient practice will not	1

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	PLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) D			(X3) DATE	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL		
		155162	B. WI	NG		07/19/	/2022	
NAME OF L	PROVIDER OR SUPPLIE	n.		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	PROVIDER OR SUPPLIE.	ĸ		600 W	ASHINGTON AVE			
AUTUM	N RIDGE REHABIL	ITATION CENTRE		WABA	SH, IN 46992			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR		TE.	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					recur, i.e., what quality	4		
					assurance program will be p into place;and	uı		
					On going compliance with this	i		
					corrective action will be monit			
					via facility QAPI program, with			
					meetings being held monthly,	and		
					is overseen by the Executive			
					Director.			
					Maintenance Supervisor or	_		
					designee will document on the	<b>;</b>		
					Egress Doors QAPI tool on weekly x 4 weeks, monthly x 3	₹		
					months, and quarterly there a			
					until compliance is achieved.			
					If Threshold of 90% is not me	an		
					action plan will be developed	łο		
					ensure compliance.			
					By what date the systemic			
					changes for each deficiency			
					will be completed. After			
					submitting an acceptable Pla of Correction, if it is	A11		
					determined that the correction	on		
					will not be completed by the			
					date previously submitted, T			
					Division needs to be contact			
					as soon as possible. The fac	ility		
					will need to submit an			
					amended plan of correction			
					with the updated plan of correction date.			
					8/17/22			
					U			
K 0293	NFPA 101							
SS=E	Exit Signage							
Bldg. 01	Exit Signage							
	2012 EXISTING							
		al signs are displayed in						
Ī	accordance with	7.10 with continuous	I		1		I	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/19/2022 155162 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE **WABASH. IN 46992** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE illumination also served by the emergency lighting system. 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 K 0293 It is the intent of this provider to 08/17/2022 failed to ensure 1 of 1 Sunroom courtyard door to have an emergency preparedness the outside of the facility would not be mistaken communication plan that complies as a facility exit. LSC 7.10.8.3.1 states any door, with Federal, State, and local passage, or stairway that is neither an exit nor a laws. way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall What corrective action(s) will be identified by a sign that reads as follows: NO be accomplished for those EXIT. The NO EXIT sign shall have the word NO residents found to have been in letters 2 inches high, with a stroke width of affected by the deficient 3/8ths inch, and the word EXIT below the word practice; NO, unless such sign is an approved existing Maintenance director put a NO sign. This deficient practice could affect 5 Exit sign on the sunroom door residents in the sun room. leading to outside courtyard. How other residents having the Findings include: potential to be affected by the same deficient practice will be Based on observations during a tour of the facility identified and what corrective with the Maintenance Director on 07/19/22 at action(s) will be taken; 11:22 p.m., the Sunroom door to the enclosed All residents have the potential to courtyard that did not lead to the public way was be affected by this deficient not posted with a "NO EXIT" sign. Based on practice. interview at the time of the observations, the What measures will be put into Maintenance Director stated the courtyard is not place and what systemic an exit to the public way and acknowledged the changes will be made to door did not have a "NO EXIT" sign posted. ensure that the deficient practice does not recur: The finding was reviewed with the Administrator The Maintenance Supervisor or during exit conference. designee will audit area to ensure the exit sign stays in proper 3.1-19(b) placement. How the corrective action(s)

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will be monitored to ensure the

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED	
		155162	B. Wl	NG		07/19/	/2022
	PROVIDER OR SUPPLIE N RIDGE REHABIL	R ITATION CENTRE		600 WA	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	ut	
					into place;and		
					On going compliance with this		
					corrective action will be monit		
					via facility QAPI program, with		
					meetings being held monthly,	and	
					is overseen by the Executive		
					Director.		
					Maintenance Supervisor or		
					designee will document on		
					Sunroom QAPI tool on weekly		
					weeks, monthly x 3 months, a	na	
					quarterly there after until		
					compliance is achieved.		
					If Threshold of 90% is not met		
					action plan will be developed	0	
					ensure compliance.		
					By what date the systemic		
					changes for each deficiency		
					will be completed. After submitting an acceptable Pla	. n	
					of Correction, if it is	311	
					determined that the correction	n .	
					will not be completed by the	)II	
					date previously submitted, T	he.	
					Division needs to be contact		
					as soon as possible. The fac		
					will need to submit an	,	
					amended plan of correction		
					with the updated plan of		
					correction date.		
					8/17/22		
K 0331	NFPA 101						
SS=E	Interior Wall and	Ceiling Finish					
Bldg. 01	Interior Wall and						
	2012 EXISTING	-					
	Interior wall and o	ceilina finishes, includina					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/19/2022 155162 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE **WABASH. IN 46992** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 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 and interview, the facility K 0331 It is the intent of this provider to 08/17/2022 failed to ensure 1 of 3 smoke barriers was have an emergency preparedness provided with a complete interior finish with a communication plan that complies flame spread rating of Class A or Class B for a with Federal, State, and local sprinklered facility. LSC 3.3.90.4 defines interior laws. wall finish as the interior finish of columns, fixed or movable walls, and fixed or movable partitions. What corrective action(s) will A.3.3.90.2 states interior finish is not intended to be accomplished for those apply to surfaces within spaces such as those residents found to have been that are concealed or inaccessible.. This deficient affected by the deficient practice could affect 15 residents on the second practice; floor. Facility requesting temporary construction waiver. Facility having Findings include: contractor come in to fix wall. How other residents having the Based on observation with the Maintenance potential to be affected by the Director on 07/19/22 at 12:30 p.m., one third of the same deficient practice will be smoke barrier above the ceiling tiles on the identified and what corrective cottage side of the second-floor 30-minute smoke action(s) will be taken; barrier wall had missing drywall which exposed Maintenance Director and the untreated wood 2x4 studs for the wall.. Based Executive Director toured facility on interview at the time of observation, the to identify all areas that have Maintenance Director agreed one side of the wall smoke barrier walls. had exposed 2x4s and acknowledged the flame What measures will be put into spread rating of the exposed wood studs was not place and what systemic known. changes will be made to ensure that the deficient 3.1-19(b) practice does not recur; The Maintenance Supervisor/designee/Executive Director will review any future

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 07/19/2022
	PROVIDER OR SUPPLIE	R ITATION CENTRE	600 W	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE 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 APPROPRIA DEFICIENCY)  smoke barrier walls to ensure	DATE
				appropriate finish.  How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance program will be pinto place; and Maintenance Supervisor or designee will complete Fire Cotool on weekly x 4 weeks, mor x 3 months, and quarterly the after until compliance is achie If Threshold of 90% is not metaction plan will be developed ensure compliance.  By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Platof Correction, if it is determined that the correction will not be completed by the date previously submitted, T Division needs to be contact as soon as possible. The fact will need to submit an amended plan of correction with the updated plan of correction date.  8/17/22	the  ut  DAPI Inthly Te  ved. It an Ito
K 0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkl are inspected, tes accordance with	- Maintenance and Testing - Maintenance and Testing er and standpipe systems sted, and maintained in NFPA 25, Standard for the ng, and Maintaining of			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155162	B. W	ING		07/19	/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			ASHINGTON AVE		
MUTUA	N RIDGE REHABIL	ITATION CENTRE			SH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Protection Systems.					
		n design, maintenance,					
		sting are maintained in a					
		nd readily available.					
	a) Date sprinklei	r system last checked					
	b) Who provided	I system test					
	c) Water system	supply source					
	Provide in REMA	RKS information on					
	coverage for any non-required or partial						
automatic sprinkler system.							
	9.7.5, 9.7.7, 9.7.8	, and NFPA 25					
	Based on observati	on and interview, the facility	K 0	353	It is the intent of this provider	to	08/17/2022
	failed to maintain t	he ceiling construction of 1 of 3			have an emergency prepared	ness	
	floors. The ceiling	tiles trap hot air and gases			communication plan that com	plies	
	around the sprinkle	er and cause the sprinkler to			with Federal, State, and local		
	operate at a specific	ed temperature. NFPA 13, 2010			laws.		
	· ·	ates the distance between the					
	_	and the ceiling above shall be			What corrective action(s) will	II	
		he type of sprinkler and the			be accomplished for those		
		n. This deficient practice			residents found to have bee	n	
		that use the first-floor therapy		affected by the deficient			
	and dining room.				practice;		
	E' 1' ' 1 1				Tile was replaced by Maintena	ance	
	Findings include:				Director.	41	
	Decided to the	4			How other residents having		
		ons during a tour of the facility			potential to be affected by the		
		nce Director on 07/19/22 at			same deficient practice will		
	_	suspended ceiling by the 2nd			identified and what corrective	/e	
		e closet, and the conference			action(s) will be taken;		
	_	es were warped or broken			Maintenance Director audited		
		suspended ceiling. This			facility and replaced ceiling tile	es	
		ay the activation of the			that were warped or broken.	al to	
	_	on the suspended ceiling.			All residents have the potentia	ai lO	
	Based on interview				be affected.	-4-	
		Maintenance Director agreed			What measures will be put in	110	
	there were gaps in	me drop cening.			place and what systemic		
	I		ı		changes will be made to		1

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER					ETED
		155162	B. WI			07/19/2	<u> </u>
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
AUTUMN	I RIDGE REHABILI	TATION CENTRE		600 WASHINGTON AVE WABASH, IN 46992			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION riewed with the Administrator		TAG	ensure that the deficient		DATE
	during the exit conf				practice does not recur;		
	8				Maintenance Director will add	to	
	3.1-19(b)				TELS monitor system and add	d to	
					routine maintenance		
					How the corrective action(s)		
					will be monitored to ensure		
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p into place;and	ut	
					QA tool will be utilized weekly	/ x 4	
					weeks, monthly x 3 months, a	nd	
					quarterly there after until		
					compliance is achieved.	t on	
					If Threshold of 90% is not me action plan will be developed	I	
					ensure compliance.		
					By what date the systemic		
					changes for each deficiency		
					will be completed. After submitting an acceptable Pla		
					of Correction, if it is	an	
					determined that the correction	on	
					will not be completed by the		
					date previously submitted, T		
					Division needs to be contact		
					as soon as possible. The fact will need to submit an	inty	
					amended plan of correction		
					with the updated plan of		
					correction date.		
					8/17/22		
K 0372	NFPA 101						
SS=E		lding Spaces - Smoke					
Bldg. 01	Barrie						
	Subdivision of Bui Barrier Construction	lding Spaces - Smoke on					

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/19/2022 155162 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE **WABASH. IN 46992** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observations, and interview, the facility K 0372 What corrective action(s) will 08/17/2022 failed to ensure 1 of 3 smoke barrier walls were be accomplished for those constructed to requirements according to the residents found to have been authority having jurisdiction (AHJ). LSC 8.2.3.1 affected by the deficient states the fire resistance of structural elements practice; and building assemblies shall be determined in The joint compound was replaced accordance with test procedure set forth in ASTM with a rated fire stop material. E 119, Standard Test Methods for Fire Tests of How other residents having the Building Construction and Materials, or ANSI/UL potential to be affected by the 263, Standard for Fire Tests of Building same deficient practice will be Construction and Materials; other approved test identified and what corrective methods; or analytical methods approved by the action(s) will be taken; AHJ. The AHJ requires penetrations in smoke All residents have the potential to barriers to be sealed with a firestop system or be affected. device tested in accordance with ASTM E 814. What measures will be put into This deficient practice could affect 15 residents on place and what systemic the second floor. changes will be made to ensure that the deficient Findings include: practice does not recur: Maintenance Director will Based on observation with the Maintenance complete an in-house audit of all Director on 07/19/22 at 12:30 p.m., above the smoke barriers to ensure ceiling tiles of the second-floor smoke barrier wall compliance. the wires through the wall were sealed with joint The Maintenance Director sealed compound and not a rated fire stop material in the wires listed on the 2567 with

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accordance with ASTM E 814. Based on interview

at the time of observation, the Maintenance Director agreed the penetrations were sealed with

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Facility ID: 000081

How the corrective action(s)

fire caulk.

If continuation sheet

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIP A. BUILDIN B. WING	PLE CONSTRUCTION  NG 01	COM	e survey pleted 9/2022
	PROVIDER OR SUPPLIEF		60	REET ADDRESS, CITY, STATE, O WASHINGTON AVE ABASH, IN 46992	ZIP COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION reviewed with the	ID PREF TA(	CROSS-REFERENCED TO	to ensure the will not	(X5) COMPLETION DATE
	_	ng the exit conference.		assurance prograinto place; and Maintenance Direct will complete the S QAPI tool weekly a monthly x 3 month there after until corachieved. If Threshold of 90% action plan will be ensure compliance By what date the s changes for each will be completed submitting an acc of Correction, if it determined that the will not be completed submitting an acc of Correction, if it determined that the will not be completed submitting an acc of Correction, if it determined that the will not be completed soon as possib will need to subm amended plan of with the updated p correction date. 8/17/22	ctor or Designee cmoke Barriers of 4 weeks, as, and quarterly impliance is of is not met an developed to e. systemic deficiency . After ceptable Plan is the correction eted by the ubmitted, The be contacted ole. The facility it an correction	
K 0741 SS=E Bldg. 01	shall include not le provisions: (1) Smoking shall ward, or compartr liquids, combustib					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED
		155162	B. WING		07/19/2022
NAME OF P	DDOVIDED OF GURDINE		STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIEF	X	600 WA	ASHINGTON AVE	
AUTUMN	I RIDGE REHABILI	TATION CENTRE	WABAS	SH, IN 46992	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		n area shall be posted with			
	l -	O SMOKING or shall be			
	I	ternational symbol for no			
	smoking.				
	1 ' '	occupancies where			
	smoking is prohib				
	1 '	d at all major entrances,			
		with language that prohibits			
	smoking shall not				
	(3) Smoking by patients classified as not responsible shall be prohibited.				
	1 -	ent of 18.7.4(3) shall not			
	` '	eatient is under direct			
	supervision.	dion is under under			
	· ·	ncombustible material and			
	1 ' '	be provided in all areas			
	where smoking is				
	_	ers with self-closing cover			
	1 ' '	n ashtrays can be emptied			
		/ailable to all areas where			
	smoking is permit				
	18.7.4, 19.7.4				
	Based on observation	on and interview; the facility	K 0741	What corrective action(s) wil	08/17/2022
		f 1 smoking areas were		be accomplished for those	
		osing only cigarette butts in		residents found to have been	n
		with a self-closing cover. This		affected by the deficient	
		ould affect 20 staff and at least		practice;	
	1 resident.			Maintenance Director remove	d
	Findings include:			cigarette packages from the	or
	i mamga metude.			cigarette butt disposal contain  How other residents having	
	Based on observation	on during a tour of the facility		potential to be affected by th	
		Director on 07/19/22 at 12:20		same deficient practice will l	
	p.m., in the staff sm	noke shack the cigarette butt		identified and what corrective	
	_	was mixed combustible		action(s) will be taken;	
	_	Based on interview at the time		All residents have the potentia	al to
		Maintenance Director agree		be affected.	
		combustible items were in the			
	cigarette butt dispo			What measures will be nut in	nto

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place and what systemic

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			
		155162	B. WING	_	07/19/2022	
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD		
ΔΙΙΤΙΙΜΑ ΔΙΙΤΙΙΜΑ	I RIDGE REHABILI	TATION CENTRE		ASHINGTON AVE SH, IN 46992		
				1		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETION DATE	
1710		viewed with the Administrator	TAG	changes will be made to	DATE	
	during exit conferen			ensure that the deficient		
	3.1-19(b)			practice does not recur;		
				Sign posted to dispose of		
				cigarettes in the smoking		
				receptacle only.		
				How the corrective action(s)		
				will be monitored to ensure the	ne	
				deficient practice will not	.=	
				recur, i.e., what quality		
				assurance program will be pu	ıt	
				into place;and		
				Maintenance Director or Design	nee	
				will complete QAPI tool weekly		
				4 weeks, monthly x 3 months, a	and	
				quarterly there after until		
				compliance is achieved.		
				If Threshold of 90% is not met		
				action plan will be developed to ensure compliance.	)	
				By what date the systemic		
				changes for each deficiency		
				will be completed. After		
				submitting an acceptable Plan	n	
				of Correction, if it is		
				determined that the correction	n	
				will not be completed by the		
				date previously submitted, Th		
				Division needs to be contacted		
				as soon as possible. The facil	lity	
				will need to submit an		
				amended plan of correction		
				with the updated plan of correction date.		
				8/17/22		
			- 1	0/1//22		

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