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	08/19/2022

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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00386966. Complaint IN00386966 - Substantiated. Federal/state deficiencies related to the allegations are cited at F609 . Survey dates: August 18 and 19, 2022. Facility number: 000081 Provider number: 155162 AIM number: 100289570 Census Bed Type: SNF/NF: 50 Total: 50 Census Payor Type: Medicare: 1 Medicaid: 40 Other: 9 Total: 50 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed August 26, 2022	F 0000		
F 0609 SS=D Bldg. 00	483.12(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including			

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	08/19/2022

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
	injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure an incident of resident to resident verbal abuse was reported immediately to the Executive Director and submitted to the State Agency in the required timeframe for 1 of 5 resident incidents reviewed (Resident F and C). Findings include: The resident to resident abuse investigation regarding Resident F and Resident C was reviewed on 8/18/22 at 1:00 p.m. A typed statement, dated 7/21/22 at 10:45 a.m. indicated Cottage Activity Assistant 7 informed the Executive Director sometime in the previous week, Resident F wheeled by the table and called	F 0609	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents F and C were followed for psychosocial distress with none noted and participating in activities per residents' baseline. Resident F now resides in room off the cottage. **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;**	09/10/2022

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	08/19/2022

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
	Resident C "stupid" and other names, but Resident C didn't hear him. During an interview with the Executive Director, on 8/18/22 at 1:32 p.m., she indicated as soon as it was reported to her, on 7/21/22, she reported it to IDOH. A current facility policy titled, "Abuse Prohibition, Reporting, and Investigation," provided by the Nurse Consultant, on 8/18/22 at 2:30 p.m., indicated the following: "...Investigation: Resident to Resident Abuse...3. The individual who witnessed the abuse will report the situation immediately to his/her supervisor and Executive Director...." This Federal Tag This Federal tag relates to complaint IN00386966. 3.1-27(b)		All residents in this facility have the potential to be affected. All staff to be in serviced by DNS/ED/Designee by 9/10/22 on Abuse policy-timely reporting abuse. Cottage Activity Assistant 7 was in serviced on 8/23/22 on timely reporting abuse. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur;** All staff to be in serviced by DNS/ED/Designee by 9/10/22 on Abuse policy-timely reporting abuse. All staff to be in serviced by ED/Designee quarterly on Abuse policy-timely reporting abuse. All reportables after 8/19/22 audited by ED/Designee for timely reporting. IDT to review any reportable in clinical meeting to identify any delay in reporting to ensure abuse policy was followed and timely. **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** The Executive Director and/or Designee will complete F609 QAPI tool weekly x4 weeks and monthly for 6 months then	

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	08/19/2022

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
			quarterly thereafter. If 100% compliance is not achieved an action plan will be implemented. The Administrator is responsible for the implementation and monitoring of this process. **By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Plan of Correction, if it is determined that the correction will not be completed by the date previously submitted, The Division needs to be contacted as soon as possible. The facility will need to submit an amended plan of correction with the updated plan of correction date.** **9/10/22** **Please review for paper compliance.**	