PRINTED: 09/22/2022 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OM	B NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155162		IDENTIFICATION NUMBER	A. BUILDING	A. BUILDING <u>00</u>		
		B. WING		08/19/	2022	
	PROVIDER OR SUPPLIER		600 WA	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	1	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
F 0000	REGGEATORT OF	KESC IDENTIFY THIS INFORMATION	1710			DATE
Bldg. 00	This visit was for the IN00386966.	he Investigation of Complaint	F 0000			
i	Complaint IN00386	6966 - Substantiated.				
	Federal/state defici	encies related to the				
	allegations are cited	d at F609 .				
	Survey dates: Augu	ust 18 and 19, 2022.				
	F 111	20001				
	Facility number: 00					
	Provider number: 1					
	AIM number: 1002	289570				
	Census Bed Type:					
	SNF/NF: 50					
	Total: 50					
	Census Payor Type Medicare: 1	::				
	Medicaid: 40					
	Other: 9					
	Total: 50					
		lects State Findings cited in 0 IAC 16.2-3.1.				
	Quality review com	npleted August 26, 2022				
F 0609 SS=D Bldg. 00		ged Violations conse to allegations of xploitation, or mistreatment,				
	§483.12(c)(1) Ens	sure that all alleged g abuse, neglect,				

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

TITLE (X6) DATE

Any defiencystatement 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 disclo 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.

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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. BUILDING <u>00</u>		COMPL	COMPLETED	
		155162	B. WING		08/19/	08/19/2022	
1.55.52				CTDEET	ADDRESS CITY STATE ZIR COD		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE		
AUTUMN RIDGE REHABILITATION CENTRE				l	SH, IN 46992		
			1		,		(V.5)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  PEGLI A TORY OR I SC IDENTIFYING INFORMATION			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG				PREFIX	CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION DATE
IAG	REGULATORY OR LSC IDENTIFYING INFORMATION injuries of unknown source and			TAG DEFICIENCY)			DATE
	1 -						
	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						
		s bodily injury, or not later					
		involve abuse and do not					
		oodily 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.						
	anough establish	ca procedures.					
	§483.12(c)(4) Rei	port the results of all					
		the administrator or his or					
	_	presentative and to other					
		ance with State law,					
		tate Survey Agency, within					
	_	f the incident, and if the					
		s verified appropriate					
	corrective action i						
	Based on record re-	view and interview, the facility	F 06	509	What corrective action(s) wi	II	09/10/2022
	failed to ensure an	incident of resident to resident			be accomplished for those		
	verbal abuse was re	eported immediately to the			residents found to have bee	n	
	Executive Director	and submitted to the State			affected by the deficient		
	Agency in the requ	ired timeframe for 1 of 5			practice;		
	resident incidents r	reviewed (Resident F and C).			Residents F and C were follo	wed	
					for psychosocial distress with		
	Findings include:				none noted and participating		
					activities per residents' baseli	ne.	
		ident abuse investigation			Resident F now resides in roo	om off	
		F and Resident C was			the cottage.		
		22 at 1:00 p.m. A typed			How other residents having		
		21/22 at 10:45 a.m. indicated			potential to be affected by tl		
	Cottage Activity Assistant 7 informed the Executive Director sometime in the previous week,				same deficient practice will		
					identified and what corrective	/e	
	Resident F wheeled	d by the table and called			action(s) will be taken;		

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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 00 COMPLETED B. WING 08/19/2022 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Resident C "stupid" and other names, but All residents in this facility have Resident C didn't hear him. the potential to be affected. All staff to be in serviced by During an interview with the Executive Director, DNS/ED/Designee by 9/10/22 on on 8/18/22 at 1:32 p.m., she indicated as soon as it Abuse policy-timely reporting was reported to her, on 7/21/22, she reported it to abuse. IDOH. Cottage Activity Assistant 7 was in serviced on 8/23/22 on timely A current facility policy titled, "Abuse reporting abuse. Prohibition, Reporting, and Investigation," provided by the Nurse Consultant, on 8/18/22 at What measures will be put into 2:30 p.m., indicated the following: place and what systemic "...Investigation: Resident to Resident Abuse...3. changes will be made to The individual who witnessed the abuse will ensure that the deficient report the situation immediately to his/her practice does not recur; supervisor and Executive Director...." All staff to be in serviced by DNS/ED/Designee by 9/10/22 on This Federal Tag This Federal tag relates to Abuse policy-timely reporting complaint IN00386966. abuse. All staff to be in serviced by 3.1-27(b) 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

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monthly for 6 months then

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 08/19/2022		
NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, 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 APPROPRIATE		(X5) COMPLETION DATE	
					quarterly thereafter. If 100% compliance is not achieved ar action plan will be implemented. The Administrator is responsil for the implementation and monitoring of this process. 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, The 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.  9/10/22  Please review for paper compliance.	ed. ble an on the ted		

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