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	03/31/2025

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 a Recertification and State Licensure Survey. Survey dates: March 25, 26, 27, 28, and 31, 2025 Facility number: 000081 Provider number: 155162 AIM number: 100289570 Census Bed Type: SNF/NF: 41 Total: 41 Census Payor Type: Medicaid: 27 Other: 14 Total: 41 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 9, 2025.	F 0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the letter of credible allegation and requests a desk review in lieu of a Post Complaint Survey Revisit on or after.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation and interview, the facility failed to protect a resident's dignity by failing to respond to a resident's request to provide needed assistance with bed mobility for toileting needs for 1 of 41 residents reviewed for dignity. (Resident 194) Findings include: During a random observation, on 3/25/25 at 10:50 a.m., Resident 194 was resting in bed on his back.	F 0550	**F550 – Resident Rights/Exercise of Rights It is the practice of this facility to ensure call lights are answered timely.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident A – all residents will be interviewed/observed weekly	04/11/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael Wolfe		04/24/2025

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	03/31/2025

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
	The head of bed (HOB) was slightly elevated. At that time, the resident was trying to use his urinal. His left foot dangled off the side of the bed. Resident 194 asked CNA 9 to reposition him in bed. CNA 9 walked toward his door and replied, "give me a second". CNA 9 had not returned to the resident's room as of 11:04 a.m. the resident had managed to get a small amount of urine into his urinal. The urinal was still positioned between his legs. At 11:05 a.m., CNA 10 entered his room. He asked CNA 10 to reposition him in bed. CNA 10 helped reposition the resident in bed before exiting his room. During an interview, on 3/25/25 at 11:08 a.m., CNA 10 indicated she was covering both halls, as the other CNA was on break. CNA 9 had not informed her that Resident 194 requested to be adjusted in bed. During an interview, on 3/25/25 at 11:10 a.m., CNA 9 indicated Resident 194 was messing with his privates and she wanted to give him privacy. The DON asked if she could help another resident, and she forgot to go back and reposition Resident 194. Resident 194's clinical record was reviewed on 3/28/25 at 9:20 a.m. Diagnoses included chronic obstructive pulmonary disease (difficulty breathing), heart failure, acute respiratory failure with hypoxia (lack of oxygen), hypertension (high blood pressure) and type 2 diabetes mellitus. Resident 194's comprehensive care plan, dated 3/20/25, indicated he required assistance with activities of daily living (ADLs) including bed mobility, transfers, eating and toileting. Interventions included to assist with bed mobility as needed.		related to call light wait times **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 by this finding. All residents will be monitored to ensure they are answered timely. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur**: All staff will be in-serviced on or before 4-11-25. This in-service will be conducted by the Executive Director and will include review of the facility policy related to Resident Rights. The Executive Director or Designee will complete the Call Light QAPI Monday – Friday. These audits will ensure that call lights are being answered 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:** Ongoing compliance with this corrective action will be monitored though the facility Quality Assurance and Performance Improvement Program. The Executive Director/designee will be responsible for completing the	

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	03/31/2025

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
	During an interview, on 3/25/25 at 2:59 p.m., Resident 32 indicated she had to wait an hour before someone assisted her. Staff would come in, turn off her call light, and leave. It would take a while before staff returned to assist her. During an interview, on 3/26/25 at 9:34 a.m., Resident 20 indicated call lights took a while to be answered. Staff would turn off the call light and leave without providing any assistance. The staff members would return, it could take a long time. During an interview, on 3/28/25 at 11:16 a.m., the DON indicated she expected staff to reposition residents when they requested. They should reposition the resident before leaving the room. It was not acceptable for residents to wait 20 or more minutes to have their call lights answered. During an interview, on 3/28/25 at 2:50 p.m., CNA 8 indicated a resident should not have to wait more than 15 minutes for their call light to be answered. If a resident asked to be repositioned, he would reposition that resident before exiting their room. During an interview, on 3/31/25 at 9:46 a.m., the administrator indicated he did not have a policy regarding answering call lights in a timely manner. 3.1-37(a)		QAPI Audit tools labeled "Call Lights" daily Monday- Friday. These will be completed until 4 weeks of 100% compliance is achieved then weekly for at least 3 months. Findings will be submitted to the Quality Assurance and Performance Improvement Committee for review and follow up. **By what date the systemic changes will be completed:** Compliance date: 4-11-25	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, interview, and record review, the facility failed to provide daily grooming assistance for nail care for 1 of 3 residents reviewed for Activities of Daily Living (ADLs). (Resident 37)	F 0677	**F667 – ADL Care Provided for Dependent Residents It is the practice of this provider to ensure that each resident who is unable to carry out activities**	04/11/2025

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	03/31/2025

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
	Findings include: During a random observation, on 3/25/25 at 11:39 a.m., Resident 37 was sitting in a recliner in front of his television. Resident 37 indicated no one has offered to cut his fingernails since his admission on 2/14/25. His nails were varying lengths between 1/16th and 1/8th inches long. Resident 37's clinical record was reviewed on 3/26/25 at 2:27 p.m. Diagnoses included fracture of the left femur, muscle weakness, anxiety, depression, essential hypertension (high blood pressure), and unspecified mood disorder. An admission Minimum Data Set (MDS) assessment, dated 2/21/25, indicated Resident 37 was cognitively intact. No behaviors were identified during the assessment period. He required set up or cleanup assistance for personal hygiene and had upper extremity impairment on one side of his body. Rejection of care was not documented during this assessment period. During a random observation, on 3/27/25 at 11:24 a.m., Resident 37 was sitting in his recliner in front of his television. Resident 37 indicated he had asked a staff member about cutting his nails. That staff member was going to notify the nurse about trimming his fingernails. His nails were long and jagged. His right thumb nail came to a point. His right index finger and middle finger were 1/16th inches long. His left thumb nail was 1/8th inch long and jagged. His left ring finger was very sharp and jagged. During an interview, on 3/27/25 at 12:28 p.m., CNA 6 indicated the CNAs would cut residents' fingernails whenever there was a need.		**of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B assisted with activities of daily living including bathing, grooming, and dressing. Staff provide nail care to each resident who is dependent. Nail care is completed per each resident's care plan and as needed. **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 who are dependent upon staff for ADL care have the potential to be affected by this finding. · Each resident who is dependent upon staff for ADL care will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene daily. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** An in-service for all certified and licensed staff will be conducted by DNS or designee on or before 4-11-25. This in-service will review the facility's essential position	

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	03/31/2025

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
	During an interview, on 3/28/25 at 10:42 a.m., CNA 7 indicated residents' fingernails were cut whenever they needed to be cut or whenever the resident would request their nails be cut. During a random observation, on 3/28/25 at 10:46 a.m., Resident 37 indicated he had asked a staff member the night before to cut his fingernails. His nails were still between 1/16th and 1/8th inches long. Seven out of his ten fingernails were sharp, jagged, or chipped. His left thumb nail being the longest. During an interview, on 3/28/25 at 11:16 a.m., the DON indicated a non-diabetic resident's fingernails are cut by either the CNA or activities. Generally, nail care was provided on shower days. Staff looked at resident fingernails routinely. Any resident who declined nailed care would have a note on the resident's shower sheet. During an interview, on 3/28/25 at 2:33 p.m., CNA 8 indicated the CNA was responsible for cutting a non-diabetic resident's nails. He cuts residents' fingernails during their PM care. If a resident declined nail care, he was unsure where that would be documented. During an interview, on 3/31/25 at 9:46 a.m., Resident 37 indicated CNA 8 had cut his thumb nails while the resident was able to cut his other fingernails. CNA 8 had left the fingernail clippers on Resident 37's bedside table for future use. He indicated it was a struggle for him to cut his fingernails. During an interview, on 3/31/25 at 2:15 p.m., the Administrator indicated he did not have a policy on nail care/ grooming nails.		functions for ADL care. · An in-house audit of each dependent resident's nail care schedule and preference will be reviewed by DNS or Designee by 4-11-25 to ensure each dependent resident is receiving nail care per their schedule and as needed. · **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:** Ongoing compliance with this corrective action will be monitored through the facility QAPI Program, with meetings being held every other month and overseen by the Executive director. ·The DNS or designee will document their findings on the "ADL Care for Dependent Residents QAPI Audit Tool" weekly for 4 weeks, monthly for 3 months, and quarterly thereafter to ensure Care Plan meetings are completed per facility policy. ·If threshold of 90% is not met, an action plan will be developed. Findings will be submitted to the Executive Director for review and follow-up. **By what date the systemic changes will be completed:** Compliance Date 4-11-25	

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	03/31/2025

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 0809 SS=D Bldg. 00	3.1-38(3)(E) 483.60(f)(1)-(3) Frequency of Meals/Snacks at Bedtime Based on observation and interview, the facility failed to offer and/or provide bedtime snacks to 6 of 6 residents reviewed for frequency of meals. (Residents 5, 6, 7, 33, 36, 37) Findings include: During a resident council meeting, on 3/26/25 at 1:27 p.m., four members were present (Residents 5, 6, 7, and 33) and each indicated bedtime snacks were offered approximately half the time. 1. Resident 37's clinical record was reviewed on 3/26/25 at 2:27 p.m. Diagnoses included fracture of the left femur, muscle weakness, anxiety, depression, hypertension (high blood pressure), and unspecified mood disorder. Current physician's orders included offering a bedtime snack. An admission MDS assessment, dated 2/21/25, indicated Resident 37 was cognitively intact. He required set up or clean-up assistance with eating. He required substantial/maximal assistance with sit to lying, lying to sitting, sit to stand, and chair/bed to chair transfer. During an interview, on 3/28/25 at 12:11 p.m., Resident 37 indicated snacks were offered at times. 2. Resident 36's clinical record was reviewed on 3/27/25 at 2:30 p.m. Diagnoses included	F 0809	**F809 It is the policy of Autumn Ridge to ensure that each resident is offered a bedtime snack, as well as other snacks throughout the day when the resident requests a snack, or as indicated by a resident's individual care plan.** **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** Residents were offered snacks at bed time following the resident council concerns brought to our attention. The nursing staff has been in-serviced on the facility policy that residents will be offered snacks - those that are scheduled throughout the day including bedtime snacks, and those that are specifically requested by the residents. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?** All residents have the potential to be affected. All residents will be offered a bedtime snack unless it is clinically contraindicated by their medical condition.	04/11/2025

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	03/31/2025

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
	myocardial infarction (heart attack), heart failure, right side hemiplegia (paralysis), generalized anxiety disorder, cerebral infarction (a stroke), and acute respiratory failure. Current physician's orders included offering a bedtime snack. An admission MDS assessment, dated 2/22/25, indicated Resident 36 was mildly cognitively impaired. He required substantial/maximal assistance with rolling to the left and right, sit to lying, lying to sitting, sit to stand, and chair/bed to chair transfer. During an interview, on 3/28/25 at 3:17 p.m., Resident 36 indicated he had never received or had been offered a bedtime snack. He took medications at bedtime and would like a snack. 3. Resident 7's clinical record was reviewed on 3/28/25 at 11:38 a.m. Diagnoses included chronic obstructive pulmonary disease, morbid obesity, type 2 diabetes mellitus, seizures, major depressive disorder, schizophrenia, heart failure and hypertension (high blood pressure). Current physician's orders included offering a bedtime snack A quarterly MDS assessment, dated 2/25/25, indicated Resident 7 was cognitively intact. He required setup or clean- up assistance with eating. 4. Resident 5's clinical record was reviewed on 3/31/25 at 9:59 a.m. Diagnoses included cerebral infarction (stroke), malignant neoplasm of breast (breast cancer), hypertension (high blood pressure), chronic kidney disease, type 2 diabetes mellitus, and heart failure.		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Snack choices will be placed on a cart, so each resident can visualize the choices available. The nursing staff will take the cart to each room to offer every resident a bedtime snack, unless a bedtime snack is clinically contraindicated by their medical condition. Social Services or designee will randomly interview the residents weekly to determine if they are being offered snacks at bedtime. She will report on the outcome of these interviews at the next scheduled IDT morning meeting. This issue will also be addressed in monthly resident council meetings, as well as through the facility's resident grievance system. Any concerns about receiving bedtime snacks will be forwarded to the Administrator and DON for further follow up as per the grievance process. If the DON finds that bedtime snacks are not being offered to residents, she will review the facility policy with the nursing staff for making snacks available to residents at various time, including at bedtime. She will also administer written counseling for those instances of continued noncompliance.	

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	03/31/2025

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
	Current physician's orders included offering a bedtime snack. A quarterly Minimum Data Set (MDS) assessment, dated 2/3/25, indicated Resident 5 was cognitively intact. She required substantial/maximal assistance with rolling to the left and right, sit to lying, and lying to sitting. She required partial/ moderate assistance with sit to stand and chair/bed to chair transfers. During an interview, on 3/28/25 at 2:23 p.m., Resident 5 indicated she received her bedtime snacks occasionally, when the facility had snacks available. 5. Resident 33's clinical record was reviewed on 3/31/25 at 3:30 p.m. Diagnoses included atrial fibrillation (irregular heartbeat), chronic kidney disease, type 2 diabetes mellitus, muscle weakness, difficulty walking, fatigue, abnormal weight loss, and Alzheimer's disease. Current physician's orders included offering a bedtime snack. An admission MDS assessment, dated 12/26/24, indicated Resident 33 was cognitively intact. He required setup or clean- up assistance with eating. He required supervision or touching assistance with sitting to stand, and chair/bed to chair transfer. 6. Resident 6's clinical record was reviewed on 3/31/25 at 3:35 p.m. Diagnoses included chronic obstructive pulmonary disease (difficulty breathing), heart failure, hypertension (high blood pressure), anxiety, type 2 diabetes mellitus, and muscle weakness.		**How the corrective action will be monitored to ensure the deficient practice will not recur?** The results of the Social Service interviews will be reviewed in the monthly QAPI meeting for a period of no less than 4 months. The QAPI team will then determine the frequency of the resident snack interviews and may discontinue the snack interview when all interviewed residents report being offered a snack every night. The DON and Social Services are responsible for implementation and monitoring of this plan. Date of compliance: 4-11-25	

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	03/31/2025

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

Current physician's orders included offering a bedtime snack.

A quarterly MDS assessment, dated 2/12/25, indicated Resident 6 was cognitively intact. She required setup or clean-up assistance with eating. She required substantial/ maximal assistance with sitting to stand, and chair/bed to chair transfers.

During an interview, on 3/28/25 at 11:41 a.m., Resident 6 indicated she asked for snacks in the past, but staff indicated they were out. She was supposed to get a cookie every night. Last night was the first time in two weeks she had received her snack.

During an interview, on 3/28/25 at 2:50 p.m., CNA 8 indicated bedtime snacks were offered when residents were placed into bed for the night. They have run out of snacks on the third floor in the past. There was a locked pantry to the right of the elevators where resident snacks were kept. At the same time as the interview, an observation of the pantry included the following: five bottles of Gatorade in the refrigerator and eight single serve fig cookie bars were inside a small plastic storage container.

During an interview, on 3/28/25 at 4:00 p.m., the Dietary Manager indicated dietary staff delivered bedtime snacks every evening. Bedtime snack options included peanut butter crackers, cottage cheese, cheese and cracks, and yogurt. The third floor dietary aide delivered the bedtime snacks when they stocked the overflow room off the lounge. The dietary aide left the bedtime snacks at the nurses station or the coffee bar in the lounge.

During an interview, on 3/28/25 at 4:23 p.m., the

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	03/31/2025

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
	DON indicated the pantry was where bedtime snacks were kept. The small room off the lounge was where dining overflow was kept. The dietary aide would bring up the resident's bedtime snacks and place them in the locked pantry. A current facility policy, dated 2/02, titled "Snacks," provided by the Administrator, on 3/31/25 at 9:46 a.m., indicated the following: " ...Snacks will be available between meals and HS snack will be offered to all residents consistent with their current diet order ...." 3.1-21 (4)(e)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control A. Based on observation and interview, the facility failed to utilize infection prevention and control practices related to hand hygiene during laundry delivery. This deficiency had the potential to affect 38 of 41 residents who received facility laundry services. B. Based on observation, interview, and record review, the facility failed to utilize infection prevention and control practices related to enhanced barrier precautions (EBP) during care for residents at a higher risk for infection for 1 of 3 residents reviewed for infection control. (Resident 32) Findings include: A1. During an observation on 3/25/25 at 10:53 a.m., Laundry Aide 11 pushed a mesh covered laundry cart down the 300 hall. She reached into an opening of the flap of the mesh curtain on the laundry cart and removed clothing on hangers	F 0880	**F880 It is the policy of Autumn Ridge to follow the policies and procedures in place for infection control, to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of communicable diseases and infections.** **What corrective action will be accomplished for those residents found to be affected by the deficient practice?** All facility staff will be educated on the Policies and Procedures of Infection Control, including the policy of not holding resident's clothing or other linen next to one's body, not placing trash cans on resident's bed or other furniture, and practicing proper handwashing. Also adhering to the	04/11/2025

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	03/31/2025

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
	from the clothing rack. She entered room 304, delivered the items and exited the room with empty hangers. She reached through the opening of the mesh flap of the laundry cart and hung them on the clothing rack. She pushed the laundry cart to room 301. She used both hands and reached into the opening of the mesh covering and removed clothing on hangers from the rack and entered room 301. She opened the closet and placed the clothing in the closet. She gathered the empty hangers and closed the closet door and exited room 102. She reached into the mesh covering and hung the empty hangers on the rack. She pushed the laundry cart to room 305. She reached into the mesh covering and removed some items that were on hangers. She entered room 305. She used her hands and opened the closet door. She hung the laundry in the closet. She touched and sorted through previously hung clothing in the closet and gathered empty hangers. She used her hands to shut the closet door. She exited the room and reached into the mesh covering of the laundry cart and hung the empty hangers on the clothing rack. Hand hygiene was not performed at any time during the observation. During a continuous observation on 3/27/25 from 10:5. to 10:55 a.m., Laundry Aide 11 pushed a laundry cart that was enclosed with a mesh covering down the 300 hall and stopped at room 324. She reached into the opening of the flap of the mesh curtain on the laundry cart and removed clothing on hangers from the clothing rack. She entered room 324. She opened the closet with her bare hands and hung up the clothing on hangers in the closet. She gathered the empty hangers and brought them out to the laundry cart. She reached into the flap of the mesh covering and hung them on the clothing rack. She reached down and		EBP protocol. **How other residents have the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** No residents were affected by this deficiency. All residents have the potential to be affected by this deficiency. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** The Administrator or Designee will audit different departments, on different shifts, to ensure all staff are following the Infection Control P&P. Audits will occur on scheduled workdays, 2x/day for 4 weeks, 1x/day for 12 weeks, then every other day for 8 weeks, for a total of 6 months. Observations will be documented on an audit tool. Any noted documentation concerns will be addressed through employee education and counseling. **How the corrective actions will be monitored to ensure the deficient practice will not recur?** The DON will review the outcomes of the audits with the QA committee, monthly. Monitoring will continue for 6 months or until 100% compliance is achieved. Once that has occurred, the Committee may decide to stop the	

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	03/31/2025

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
	grabbed clothing items from a small bin located on the bottom rack of the laundry cart. She re-entered room 324 and using her hands she opened a drawer and placed items into the drawer. She used her hands to close the drawer and exited the room. She pushed the laundry cart to room 325. She reached into the opening of the mesh flap and removed clothing on hangers. She entered room 325 and shut the door. She exited room 325. She pushed the laundry cart to room 326. She reached into the opening of the mesh covering of the cart and retrieved clothing on hangers as well as clothing items from the bins located on the bottom rack of cart. She placed the hangers in her left hand and using her right hand placed the items from the bins into the crook of her left elbow, holding them against her scrub top. She entered room 326 and hung the items in the closet and placed the other items in drawers. She exited room 326 and shut the door. She then pushed the laundry cart to room 303. She reached through the mesh opening and removed the clothing on hangers from the clothing rack and entered room 303. She opened the closet doors and hung-up items. She sorted through the closet and retrieved empty hangers. She closed the closet doors and exited the room. She reached into the mesh covering and placed the empty hangers on the clothing rack. She pushed the laundry cart to room 304. She reached into the opening of the mesh covering and retrieved the clothing on hangers and placed it into her left hand. She leaned over and retrieved socks and cloth pads from bins on the lower rack of the laundry cart. She placed the socks and a cloth pads in the crook of her left elbow and held them up against her scrub top. She knocked on the door of room 304, introduced self, and took items into the room. After hanging items in the closet and putting away the socks and cloth pads, she exited the		written audits; however, the process as described in question will continue ongoing. The Administrator will be responsible for the implementation and monitoring of this plan. Date of compliance: 4-11-25	

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	03/31/2025

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
	room and shut the door. She pushed the laundry cart to room 306. She reached into the opening of the mesh covering and retrieved clothing on hangers. She knocked on room 306 door and entered. She opened the closet and hung the items up, closed the closet doors, and exited the room. She pushed the laundry cart to room 309. She reached into the opening of mesh covering and removed items on hangers from the cart and took them into room 309. She opened the closet door, hung up the items, and shut the closet door. She exited and shut the door. Hand hygiene was not performed at any time during the continuous observation. During an interview, on 3/27/25 at 10:58 a.m., Laundry Aide 11 indicated hand hygiene was to be performed when she exited resident rooms. Hands are contaminated after touching knobs and dressers. During an observation, on 3/28/25 at 10:51 a.m., Laundry Aide 11 pushed a laundry cart that was enclosed with a mesh covering down the 300 hall to room 304. She reached into the opening on the mesh covering and retrieved items on hangers. She entered room 304. She opened the closet door and hung the items in the closet. She closed the closet door and exited the resident's room. She pushed the laundry cart to room 306. She reached into the mesh covering and retrieved items on hangers and took them into room 306. No hand hygiene was observed when room 304 was entered and exited and no hand hygiene performed when room 306 was entered. During an interview on 03/31/25 at 11:19 a.m., the Assistant Housekeeping and Laundry Supervisor indicated laundry staff passed out residents' clean laundry and hand hygiene was to be performed			

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	03/31/2025

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
	each time a laundry staff member entered and exited resident rooms due to hand contamination when closets and drawers were touched. During an interview on 3/31/25 at 3:44 p.m., the Maintenance and Laundry Supervisor indicated 38 of the 41 residents received laundry services from the facility. B1. During an observation on 3/25/25 at 2:59 p.m., Resident 32 had a personal protective equipment (PPE) cart against the wall at the foot of her bed. Resident 32's clinical record was reviewed on 3/31/25 at 10:40 a.m., Diagnoses included surgical aftercare following surgery on the digestive system, rectal abscess, malignant neoplasm of cervix uteri, and Enterococcus as the cause of diseases classified elsewhere-blood culture and port. A physician's order, dated 3/22/25, included Heparin (an anticoagulant) lock flush, pre-filled syringe 10 units/milliliters (mL), administer 2.5 mL intravenously every 6 hours. Special instructions: Flush central line following normal saline per saline, administer, saline, heparin (SASH) to maintain patency. A physician's order, dated 3/22/25, included Pre-Filled Normal Saline (sodium chloride 0.9 %) syringe, administer 10 mL every 6 hours. Flush central line before and after antibiotic administration to maintain patency. The clinical record lacked an order for EBP. A quarterly Minimum Data Set (MDS) assessment, dated 3/4/25, indicated the resident was cognitively intact. She received central line			

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	03/31/2025

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
	IV medications. A current care plan, dated 3/14/25, indicated the resident had a central line IV access to the left upper chest and was at risk for infection and complications. Interventions included flush as ordered (1/6/25) and observe insertion site for signs of infiltration, redness, swelling, tenderness, coolness, and non-functioning access (1/6/25). The clinical record lacked a care plan or interventions for EBP. During an observation of central line flushing, on 3/31/25 at 10:52 a.m., LPN 3 placed items needed for central line flush on resident's bedside table. She performed hand hygiene and applied gloves. She indicated she had forgotten the alcohol prep pads. She removed her gloves, threw them in the trash, and exited the room. She returned at 10:55 a.m. She performed hand hygiene and applied gloves. She removed one of the double lumen line caps. She cleansed the IV tip with an alcohol prep pad. She flushed the line with a 10 mL prefilled syringe of normal saline, followed with the Heparin prefilled syringe. She applied a new cap to the IV line. She then removed the cap from the second lumen and cleansed the IV tip with an alcohol prep pad. She flushed line with a 10 mL syringe of normal saline, followed with the Heparin prefilled syringe. She applied a new cap to the IV line. She discarded trash, removed her gloves, and performed hand hygiene. LPN 3 did not don additional PPE during the central line access. During an interview, on 3/31/25 at 11:01 a.m., LPN 3 indicated staff was made aware of residents' on EBP through the resident profile and face sheet located in residents' electronic chart. All residents			

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	03/31/2025

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
	on contact, droplet, standard isolation, and those on EBP precautions all require the same PPE. Staff should use additional PPE when caring for Resident 32. During an interview, on 3/31/25 at 11:22 a.m., LPN 3 indicated EBP signs were posted beside the PPE carts. She did not put on the required PPE when she flushed Resident 32's central line. During an interview, on 3/31/25 at 11:28 a.m., the DON and Corporate Nurse indicated that staff were made aware of residents on EBP because it was on their care sheets and in their profile. EBP signage was on the wall in the resident's room. If sharing a room, the signage and EBP cart would be on the resident's side that needed the EBP. EBPs were required for indwelling catheters, wounds, feeding tubes, tracheostomies, certain MDROs, peritoneal dialysis, and anything invasive. During an interview, on 3/31/25 at 2:07 p.m., CNA 14 indicated EBP signs were posted on the resident's door or by the PPE cart in the residents' room. Residents that needed EBP were those who had COVID-19, flu, and anyone that had an illness that could be transmitted through airborne or touch. During an interview, on 3/31/25 at 2:49 p.m., the DON indicated if a resident had a central line or a foley catheter, staff was to wear EBP when they were doing hands-on care. EBP consisted of a gown and gloves. EBP signs were posted in resident rooms on the side of room that the resident resided on. A current facility policy, last revised 12/2021, titled, "Laundry/Linen," provided by the			

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	03/31/2025

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
	Assistant Housekeeping and Laundry Supervisor on 3/31/25 at 11:33 a.m., included the following: "...Purpose of Policy: To ensure the proper care and handling of linen and laundry to prevent the spread of infection. Policy: The laundry and nursing staff shall handle, store, process, and transport linen appropriately to prevent the spread of infection, in resident-care areas and in the laundry facility. Procedure...2. Resident care areas: clean linen: a. Clean linen must be protected from soiling or contamination ...i. Clean linen should be carried away from body to prevent contamination ...,4. Laundry area: ... e. Before removing or touching clean laundry - perform hand hygiene ...." A current facility policy, last revised September 2023, titled, "Standard and Transmission-Based Precautions (Isolation) Policy" provided by the Administrator on 3/31/25 at 9:46 a.m., indicated the following: "...ENHANCED BARRIER PRECAUTIONS: ...expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated, it refers to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing ... Resident Placement: Post Enhanced Barrier Precautions sign on the resident door or on wall above room identifier ... Use of Personal Protective Equipment - Gown and Gloves: During high-contact resident care activities ...device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator ...." An undated corporate document, provided by the DON on 3/31/25 at 3:05 p.m., indicated providers and staff must wear gloves and a gown for the following high-contact resident care activities: ... Device Care or Use:central line, urinary catheter,			

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	03/31/2025

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
	feeding tube, tracheostomy .... 3.1-18(l) 3.1-18(b)(2)			