STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155162	A. BUILDING -- B. WING	04/28/2025

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 04/28/25 Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570 At this Emergency Preparedness survey, Autumn Ridge Rehabilitation Centre was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 75 and had a census of 37 at the time of this survey. Quality Review completed on 04/30/25	E 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 any violation of regulation. This provider respectfully requests that the 2567 POC be considered the letter of credible allegation. The facility respectfully requests a desk review in lieu of a revisit.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 04/28/25 Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570 At this Life Safety Code survey, Autumn Ridge Rehabilitation Centre was found not in compliance with Requirements for Participation in	K 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 any violation of regulation. This provider respectfully requests that the 2567 POC be considered the letter of credible allegation. The facility respectfully requests a desk review in lieu of a revisit.	

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

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	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This three-story facility was determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in corridors, areas open to the corridor, and hard-wired smoke detectors in resident rooms 301-306 and 324-326, all remaining resident rooms had battery operated smoke detectors. The facility is fully protected by a type II EES diesel powered generator. The facility has a capacity of 75 and had a census of 37 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached sheds used for storage of maintenance parts. Quality Review completed on 04/30/25			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure the corridor doors to 1 of 1 beauty shops being used for the storage of combustible materials and greater than 50 square feet was provided with a self-closing device which would cause the door to automatically close and latch into the door frame. This deficient practice affects 20 residents in one smoke compartment. Findings include:	K 0321	1 The room is no longer used for storage. 2 All residents had the potential to be affected by this deficient practice. The maintenance director or designee will check all storage areas ensuring that the doors are functioning properly and self closing/latching. 3 The maintenance director or	04/29/2025

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	Based on observations with the Maintenance Director and Administrator on 04/28/25 at 1:08 p.m., the beauty shop contained two full skids of supply boxes, was greater than 50 square feet, and was not protected as a hazardous area. The door to the room was equipped with a self-closing device but the latch on the door was a manual turn latch and not an automatically closing latch. Based on interview at 1:08 p.m., the Maintenance Director agreed the room was used as storage, was larger than 50 square feet, and the latch would not automatically latch into the frame. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference at 2:30 p.m. 3.1-19(b)		designee will round weekly to ensure all storage doors have self closing and self latching mechanisms. 4 Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and overseen by the Executive Director. The Maintenance Director or designee will document on the K321 tag QAPI tool weekly x4, monthly x6, and quarterly there after until compliance is achieved. If 100% is not achieved an action plan will be developed. 5 4/29/2025	
K 0355 SS=E Bldg. 01	NFPA 101 Portable Fire Extinguishers Based on observation and interview, the facility failed to ensure 2 of 11 portable fire extinguishers had the 6-year maintenance conducted in accordance with NFPA 10. NFPA 10, 2010 Edition, Section 7.3.1.1.2 states fire extinguishers shall be internally examined at intervals not exceeding those specified in Table 7.3.1.1.2. Section 7.3.1.2.1 states every six years, stored pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable internal examination procedure as detailed in the manufacturer's service manual and this standard. Sections 7.3.3.1 through 7.3.3.2 state fire extinguishers that pass the applicable 6-year requirement shall have the maintenance information recorded on a durable weatherproof label that is a minimum size of 2 inches by 3.5 inches. The label shall be affixed to the shell and	K 0355	1 These 2 extinguishers have been replaced and have correct tags/dates displayed on them 2 All residents had the potential to be affected by this deficient practice. All fire extinguishers were checked to ensure that they are all up to date by the Maintenance Director. 3 The Maintenance Director or designee will round weekly to ensure fire extinguishers are in compliance and dated correctly. 4 Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and overseen by the	04/29/2025

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	shall include the month and year the maintenance was performed. The label shall include the initials of the person performing the maintenance and the name of the agency performing the maintenance. A verification of service collar shall be located around the neck of the container indicating the month and year of service and the name of the agency performing the maintenance or recharge. This deficient practice could affect 25 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director and Administrator on 04/28/25 at 1:28 p.m. and 1:46 p.m., the ABC type portable fire extinguishers located by rooms 146 and 208 each had a 6-year maintenance collar affixed to the extinguishers with a completion date of January of 2018, making the 6-year maintenance past due. Based on an interview at 1:28 p.m. and 1:46 p.m., the Maintenance Director agreed each of the two portable fire extinguishers were past due for the 6-year maintenance. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference at 2:30 p.m. 3.1-19(b)		Executive Director. The Maintenance Director or designee will document on the K355 tag QAPI tool weekly x4, monthly x6, and quarterly there after until compliance is achieved. If 100% is not achieved an action plan will be developed. 5. 4/29/2025	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Based on observation and interview, the facility failed to ensure 1 of 1 dining room smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier	K 0374	1 Facility has received a quote to replace the door to the kitchen, see attachment. The facility will have the old door removed and the new one install on or before 5-28-25 pending delivery.	05/28/2025

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	shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 25 residents in the dining room Findings include: Based on observations with the Maintenance Director and Administrator on 04/28/25 at 12:54 p.m., the set of smoke barrier doors in the smoke barrier wall between the kitchen and dining room would not close due to the coordinating device on the door frame not correctly working. When tested, the coordinating device would hold both doors open when the door without the astragal was shut first. This condition creates a one-inch gap between the doors when shut. Based on an interview at 12:54 p.m., the Maintenance Director stated the coordinating device did not function properly and did not allow the doors to completely shut. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference at 2:30 p.m. 3.1-19(b)		2 All residents had the potential to be affected by this deficient practice. All smoke barrier doors were checked to ensure they all function properly by the Maintenance Director. 3 The Maintenance Director or designee will round weekly to ensure that the smoke barrier doors are functioning properly. 4 Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and overseen by the Executive Director. The Maintenance Director or designee will document on the K374 QAPI tool weekly x4, monthly x6, and quarterly there after until compliance is achieved. If 100% is not achieved an action plan will be developed. 5 5/28/25	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 1 of 1 receptacles within 6 feet from a sink or located in a wet location were provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault	K 0511	1 Outlet within 6 feet of sink in dining room was changed to a GFCI protected outlet. 2 All residents had the potential to be affected by this deficient practice. All outlets within 6 feet of water source were checked to ensure they are GFCI protected by the Maintenance Director.	04/29/2025

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	Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms, (2) Kitchens, (3) Rooftops, (4) Outdoors, (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. (6) Indoor wet locations, (7) Locker rooms with associated showering facilities, (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of the wet location to have GFCI protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect 5 residents in the therapy gym. This deficient practice could affect 25 residents in the dining room. Findings include: Based on observations with the Maintenance Director and Administrator on 04/28/25 at 12:48 p.m., the receptacle by the sink in the dining room measured 5 feet from the water source and was not GFCI protected. Based on an interview at 12:48 p.m., the Maintenance Director agreed the electric receptacle by the sink in the dining room was not GFCI protected.		3 The Maintenance Director will round weekly to ensure they outlets are GFCI protected and functioning properly. 4 Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and overseen by the Executive Director. The Maintenance Director or designee will document on the K511 tag QAPI tool weekly x4, monthly x6, and quarterly there after until compliance is achieved. If 100% is not achieved an action plan will be developed. 4/29/2025	

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	This finding was reviewed with the Maintenance Director and the Administrator during the exit conference at 2:30 p.m. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure 2 of 2 power cord daisy chains were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. Article 400.8 (1) prohibits daisy chains, because the first extension cord (or power strip) is now acting as a substitute for the fixed wiring of a structure. This deficient practice could affect up to 15 residents in one smoke compartment. Findings include: Based on observations with the Maintenance Director and Administrator on 04/28/25 at 12:40 p.m., the IT closet in the Administrators office had a power strip and a multi-plug adapter plugged into and supplied power by another power strip. Based on an interview at 12:40 p.m., the Maintenance Director and Administrator confirmed a power strip, and a multi-plug adapter were daisy chained to another power strip. This finding was reviewed with the Maintenance Director and the Administrator during the exit conference at 2:30 p.m. 3.1-19(b)	K 0920	1 Power strips were removed from the Executive Director's closet. They have been replaced with an APC battery back up plugged directly in the wall. 2 All residents had the potential to be affected by the deficient practice. All power strips used in the facility were checked to ensure there were none with power strips interlinked. 3 The Maintenance Director will round weekly to ensure that there is no power strips plugged into other power strips. 4 Ongoing compliance with this corrective action will be monitored via facility QAPI program, with meetings being held every other month, and overseen by the Executive Director. The Maintenance Director or designee will document on the K920 tag QAPI tool weekly x4, monthly x6, and quarterly there after until compliance is achieved. If 100% is not achieved an action plan will be developed. 5 5/9/2025	05/09/2025