STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING 01 B. WING	06/24/2025

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
K 0000 Bldg. 01	A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 04/28/25 was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/24/25 Facility Number: 000081 Provider Number: 155162 AIM Number: 100289570 At this PSR survey, Autumn Ridge Rehabilitation Centre was found in substantial compliance with Requirements for Participation in 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 39 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	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
Michael Wolfe	Executive Director	07/07/2025

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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	parts. Quality Review completed on 06/25/25			
K 0363 SS=B Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 1 of 1 corridor doors to the Beauty Shop was provided with a means suitable for keeping the door closed and latched into the door frame. This deficient practice could affect residents in or near the Beauty Shop. Findings include: Based on observation with the Regional VP of Operations and the Business Office Manager on 06/24/25 at 12:09 p.m., the corridor door to the Beauty Shop lacked positive latching hardware and failed to latch into the door frame. The Beauty Shop was cited on the recertification survey on 04/28/25 as a hazardous area that lacked protection. The combustible material was removed from the Beauty Shop and it's no longer considered a hazardous area. Based on interview at the time of observation, the Regional VP of Operations and the Business Office Manager agreed the corridor door to the Beauty Shop would not latch into the door frame and was equipped with a manually locking mechanism. These findings were reviewed with the Regional VP of Operations and the Business Office Manager during the exit conference. 3.1-19(b)	K 0363	1 The beauty shop door now has a positive latching door. 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 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 K363 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. 7/7007/07/2025	07/07/2025