EPARTMENT OF HEALTH AND HUMAN SERVICES								
ENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION						

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155162		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/12/2024	
	PROVIDER OR SUPPLIER			600 WA	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORE PREFIX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)		TE	(X5) COMPLETION	
TAG E 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY		DATE	
Bldg	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/12/24 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 33 at the time of this survey.		E 00	000	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	Quality Review completed on 07/16/24 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: 07/12/24 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 0	000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set in the statement of deficiencie any violation of regulation. The provider respectfully requests the 2567 POC be considered letter of credible allegation. The facility respectfully requests a desk review in lieu of a revisit.	ot s forth s or iis that the		

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

TITLE (X6) DATE

Michael Wolfe Executive Director 08/06/2024

Any defiency statement 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 disclodays 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 AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155162		r í	JILDING	nstruction 01	(X3) DATE COMPL 07/12 /	ETED	
	ROVIDER OR SUPPLIER I RIDGE REHABILI			600 WA	DDRESS, CITY, STATE, ZIP COD SHINGTON AVE SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓΕ	(X5) COMPLETION DATE
	Life Safety from Fin National Fire Protect Life Safety Code (L Health Care Occupa	te and the 2012 edition of the etion Association (NFPA) 101, SC), Chapter 19, Existing ancies and 410 IAC 16.2.					
	sprinklered. The fa with smoke detection to the corridors and detectors in the residual	cility has a fire alarm system on in the corridors, areas open battery powered smoke dent sleeping rooms. The ty of 75 and had a census of					
		•					
K 0222 SS=F Bldg. 01	be equipped with a requires the use of egress side unless special locking arr CLINICAL NEEDS LOCKING Where special lock clinical security nest used, only one lock permitted on each be made for the response to the response of the response	d means of egress shall not a latch or a lock that f a tool or key from the susing one of the following angements: SOR SECURITY THREAT king arrangements for the teds of the patient are king device shall be door and provisions shall apid removal of occupants of locks; keying of all ed by staff at all times; or e means available to the					

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Event ID:

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	01	COMPL	ETED
		155162	B. WING			07/12/	2024
			S	TREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			SHINGTON AVE		
AUTUMN	N RIDGE REHABILI	TATION CENTRE	V	VABAS	SH, IN 46992		
(X4) ID		STATEMENT OF DEFICIENCIE		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	i	R LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE
		.2.2.6, 19.2.2.2.5.1,					
	19.2.2.2.6						
	SPECIAL NEEDS						
	ARRANGEMENT						
	-	king arrangements for the					
		e patient are used, all of					
		curity Locking requirements					
	-	addition, the locks must be					
		at fail safely so as to					
		of power to the device; the					
		ed by a supervised					
	automatic sprinkler system and the locked						
	space is protected by a complete smoke						
	· · · · · · · · · · · · · · · · · · ·	(or is constantly monitored					
		ation within the locked					
		the sprinkler and detection					
		iged to unlock the doors					
	upon activation.	2252 TIA 42 4					
	18.2.2.2.5.2, 19.2 DELAYED-EGRE						
	ARRANGEMENT						
		lelayed-egress locking					
		in accordance with					
	7.2.1.6.1 shall be						
		g low and ordinary hazard					
		igs protected throughout by					
		ervised automatic fire					
		or an approved, supervised					
	automatic sprinkle						
	18.2.2.2.4, 19.2.2	_					
	ACCESS-CONTR						
	LOCKING ARRAN						
		d Egress Door assemblies					
		lance with 7.2.1.6.2 shall					
	be permitted.						
	18.2.2.2.4, 19.2.2	.2.4					
		BY EXIT ACCESS					
	LOCKING ARRAN						
		t access door locking in					
	-	7.2.1.6.3 shall be permitted					

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PRINTED: 08/06/2024 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 07/12/2024 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 What corrective action(s) will 1. Based on observation and interview, the facility K 0222 07/15/2024 failed to ensure all exterior exit doors were readily be accomplished for those accessible and able to open on first try. This residents found to have been

Findings include:

facility.

Based on an observation and interviews during a tour of the facility with the Executive Director (ED) and the Maintenance Director from another building (MD) on 07/12/24 between 11:50 a.m. and 2:15 p.m., the service hall near the kitchen exit door would not open easily on the first try when tested. The Surveyor, then the MD tried to open the door, and the Maintenance Director was able. after several tries and considerable effort to open the door.

deficient practice could affect all occupants in the

This finding was acknowledged by the ED and MD at the time of discovery and again at the exit conference.

2. Based on observation and interview, the facility failed to ensure the means of egress for 3 of the exit doors was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect all staff, residents

affected by the deficient practice: Door frame fixed and door closure

adjusted for the kitchen exit door. Doors with a means of egress exit code was placed in area accessible to staff and residents. 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 had the potential to be affected by this deficient practice.

What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur: All exterior exit doors were tested to ensure doors opened easily and on first try by Maintenance

Director. All exit doors with codes were audited to ensure codes were easily accessible by the Maintenance Director. The maintenance supervisor or designee will round weekly to ensure exit doors are easily open and codes are accessible.

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	, ,	UILDING	onstruction 01	COMP	E SURVEY PLETED 2/2024
	PROVIDER OR SUPPLIEI I RIDGE REHABILI		-	600 WA	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992	-	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N BE	(X5) COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DATE		
	Findings include: Based on an observe tour of the facility of and the Maintenand building (MD) on C2:15 p.m., the followith a code which of figure out in the every special knowledge surveyor had to be posted above the document of the composition of the compos	ration and interviews during a with the Executive Director (ED) the Director from another 107/12/24 between 11:50 a.m. and wing exit doors were posted was deemed too challenging to the ent of an emergency requiring to know where to look. The shown where the code was bor on the mechanism. door near RR# 309. door near RR# 315. door near RR# 301. Eknowledged by the ED and discovery and again at the exit			How the corrective actions will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be into place On going compliance with the corrective action will be monitored in the place of	re the put his nitored vith other the signee oor nere nieved. I be cy Plan ction he l, The acted facility	
K 0225 SS=E Bldg. 01	Stairways and Sm	nokeproof Enclosures nokeproof Enclosures nokeproof enclosures used					

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155162		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 01 COMPLETE B. WING 07/12/202			LETED	
	PROVIDER OR SUPPLIE			600 WA	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
TAG	as exits are in acc 18.2.2.3, 18.2.2.4 Based on observatifailed to ensure 1 of were in accordance 7.2.1.5.10 requires on a door leaf to be device that has an earlier and is readily operations. This desidents staff a Findings include: Based on an observation of the facility and the Maintenance building (MD) on 0.2:15 p.m., the later door near RR# 309 door failed to self-or this finding was according to the self-or this finding to the self-or this	vation and interviews during a with the Executive Director (ED) are Director from another 07/12/24 between 11:50 a.m. and a on the 3rd floor stairwell exit was not functioning and the	K 0	225	What corrective action(s) will accomplished for those reside found to have been affected by deficient practice; ="" p=""> Latch on stairwell exit door repaired- does self-close and 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 had the potential be affected by this deficient practice. The maintenance supervisor or designee will complete an in-house audit of stairwells exit doors to ensure further compliance What measures will be put intended by the same deficient practice does not recompliance. What measures will be put intended by the same deficient practice does not recompliance. What measures will be put intended by the same deficient practice does not recompliance. What measures will be put intended by the same deficient practice does not recompliance. What measures will be put intended by the same deficient practice does not recompliance. What measures will be put intended by the same deficient practice does not recompliance. What measures will be put intended by the same deficient practice does not recompliance. What measures will be put intended by the same deficient practice does not recompliance. What measures will be put intended by the same deficient practice does not recompliance. What measures will be put intended by the same deficient practice does not recompliance. What measures will be put intended by the same deficient practice does not recompliance. What measures will be put intended by the same deficient practice does not recompliance.	latch ne e all to f all e to nges ne cur; ee sure and will be ient nat iil be s tored h	07/15/2024

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155162		A. BUILDING B. WING	01	COMPLETED 07/12/2024	
	PROVIDER OR SUPPLIER		600 WA	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0321	NEDA 101			month, and is overseen by the Executive Director. The Maintenance Director or design will document on the Stairwell Door K225 QAPI tool weekly monthly x6, and quarterly ther after until compliance is achie If 100% is not achieved an acriplan will be developed By what date the systemic changes for each deficiency who is determined that the correction is determined that the correction will not be completed by the dipreviously submitted, The Divineeds to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated placorrection date. 7/15/24	gnee Exit k4, re ved. tion vill g an , if it on ate ision n as to
SS=E Bldg. 01	barrier having 1-hd (with 3/4 hour fire automatic fire extir accordance with 8 approved automat option is used, the from other spaces partitions and door Doors shall be self automatic-closing nonrated or field-a	- Enclosure are protected by a fire our fire resistance rating rated doors) or an aguishing system in .7.1 or 19.3.5.9. When the ic fire extinguishing system areas shall be separated by smoke resisting rs in accordance with 8.4.			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155162	B. W	NG _		07/12/	/2024
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t			ASHINGTON AVE		
AUTUMN	I RIDGE REHABILI	TATION CENTRE			SH, IN 46992		
ı	111100211211110121	, the telephone and the teleph	1		1		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the door.						
		and zone locations of					
		that are deficient in					
	REMARKS.						
	19.3.2.1, 19.3.5.9						
	Area	Automatic Sprinkler					
	Separation	N/A -Fired Heater Rooms					
		er than 100 square feet)					
	, -						
	c. Repair, Maintenance, and Paint Shops						
	d. Soiled Linen Rooms (exceeding 64 gallons)						
	e. Trash Collection	n Rooms					
	(exceeding 64 gal						
		orage Rooms/Spaces					
	(over 50 square fe	- ·					
		classified as Severe					
	Hazard - see K322						
		on and interview, the facility	K 0	321	What corrective action(s) will be	ne.	07/15/2024
		corridor doors to 2 of over 8	10	521	accomplished for those reside		07/13/2021
	hazardous rooms w				found to have been affected b		
		which would cause the door to			deficient practice;	,	
		and latch into the door frame.			Latch on storage room door		
	_	ice could affect 5 staff.			repaired- does self-close and	latch	
	•				for room 222 and room 201.		
	Findings include:						
	-				How other residents having the	е	
	Based on an observa	ation and interviews during a			potential to be affected by the		
	tour of the facility v	with the Executive Director (ED)			same deficient practice will be		
	and the Maintenanc	e Director from another			identified and what corrective		
	building (MD) on 0	7/12/24 between 11:50 a.m. and			action(s) will be taken		
	2:15 p.m., the corrid	dor doors to the following			All residents had the potential	to	
	hazardous areas did	not meet the requirements for			be affected by this deficient		
	protection of a haza	rdous area:			practice. The Maintenance dire	ector	
	a) Resident Room # 222, larger than 50 square feet and being used for storage, had a self-closing device on the door but it failed to self-close and				or designee will complete an		
					in-house audit of all storage do	oors	
					to ensure further compliance		
	latch positively into	the door frame.					
	b) Resident Room #	‡ 201, larger than 50 square feet			What measures will be put into)	

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	D PLAN OF CORRECTION IDENTIFICATION NUMBER 155162		A. BUILDING 01 B. WING		COMPLETED 07/12/2024	
	PROVIDER OR SUPPLIER		600 WA	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	device on the door be latch positively into This finding was acl	storage, had a self-closing but it failed to self-close and the door frame. knowledged by the ED and iscovery and again at the exit		place and what systemic chan will be made to ensure that the deficient practice does not recommendate the maintenance Director/designee will complete house audit of all storage room doors to ensure storage room doors self-close and latch. How the corrective action(s) we monitored to ensure the deficing practice will not recur, i.e., who quality assurance program will put into place On going compliance with the corrective action will be monitorially active active action will be well active active action active active active action active active action plan will be developed By what date the systemic changes for each deficiency well be completed. After submitting acceptable Plan of Corrections is determined that the correction is determined that the correction will not be completed by the dipreviously submitted, The Divineeds to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated plan of correction with	e in m rill be ent est libe ored er est libe	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155162		A. BUILDING	E CONSTRUCTION G 01	COMPLE	(X3) DATE SURVEY COMPLETED	
		155162	B. WING		- 07/12/2	024
	PROVIDER OR SUPPLIER		600	EET ADDRESS, CITY, STATE, ZIP CO WASHINGTON AVE BASH, IN 46992	DD	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	(EACH DEFICIEN	EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD BE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
				correction date. 7/15/24		
K 0325	NFPA 101					
SS=E		nd Rub Dispenser (ABHR)				
Bldg. 01		nd Rub Dispenser (ABHR)				
	ABHRs are protected in accordance with					
	· ·	conditions are met:				
	* Corridor is at lea					
		dual dispenser capacity is				
		gallons in suites) of fluid				
	and 18 ounces of					
	horizontal spacing	have a minimum of 4-foot				
		n aggregate of 10 gallons of				
		s aerosol are used in a				
		partment outside a storage				
	_	one individual dispenser				
	per room	•				
	* Storage in a sing	gle smoke compartment				
	greater than 5 gal	lons complies with NFPA				
	30					
	•	not installed within 1 inch of				
	an ignition source					
		carpeted floors are in				
	sprinklered smoke	•				
		exceed 95 percent alcohol dispenser shall comply				
		2.6(11) or 19.3.2.6(11)				
		ed against inappropriate				
	access	ed against mappropriate				
		, 42 CFR Parts 403, 418,				
	460, 482, 483, and					
		on and interview, the facility	K 0325	What corrective action(s) will be	07/15/2024
	failed to ensure 1 of	f over 20 alcohol-based hand		accomplished for those	· .	-
	sanitizer dispensers	were not installed over an		found to have been affe		
	_	PA 101, Section 19.3.2.6(8)		deficient practice;		
	_	all not be installed in the		ABHR moved away from	m the light	
	following locations			switch in room 209.		
	(a) Above an ignition source within a 1-inch					

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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 COMPLETED 01 B. WING 07/12/2024 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 DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE horizontal distance from each side of the ignition How other residents having the source potential to be affected by the (b) To the side of an ignition source within a same deficient practice will be 1-inch horizontal distance from the ignition source identified and what corrective (c) Beneath an ignition source within a 1-inch action(s) will be taken: vertical distance from the ignition source All residents had the potential to This deficient practice could affect 2 residents in be affected by this deficient one smoke compartment. practice. The Maintenance director or designee will complete an Findings include: in-house audit of all alcohol-based hand sanitizer dispensers above Based on an observation and interviews during a any electrical outlets/light tour of the facility with the Executive Director (ED) switches to ensure further and the Maintenance Director from another compliance. building (MD) on 07/12/24 between 11:50 a.m. and 2:15 p.m., an alcohol-based hand sanitizer What measures will be put into dispenser was installed on the wall directly above place and what systemic changes a light switch in Resident Room # 209. Based on will be made to ensure that the interview at the time of observation, the Executive deficient practice does not recur; Director confirmed the alcohol-based hand ="" p=""> sanitizer dispenser was installed on the wall Any new installation of ABHR will directly above switch. be observed to ensure it is not installed over an ignition source. This finding was acknowledged by the ED and The Maintenance Director will be MD at the time of discovery and again at the exit inserviced on the appropriate conference. location for installation of ABHR by the ED/Designee. 3.1-19(b) 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 On-going compliance with the corrective action will be monitored via facility QAPI program, with meetings being held every other month, and is overseen by the Executive Director. The Maintenance Director or designee will document on the ABHR K325

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155162	B. WI	NG		07/12/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				SHINGTON AVE		
AUTUMN	RIDGE REHABILI	TATION CENTRE	WABASH, IN 46992				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	QAPI tool weekly x4, monthly		DATE
					and quarterly there after until compliance is achieved. If 100		
					not achieved an action plan wi developed.		
					By what date the systemic		
					changes for each deficiency w be completed. After submitting		
					acceptable Plan of Correction,		
					is determined that the correction		
					will not be completed by the da		
					previously submitted, The Divi needs to be contacted as soor		
					possible. The facility will need		
					submit an amended plan of		
					correction with the updated pla	an of	
					correction date. 7/15/24		
					1710/24		
K 0353	NFPA 101						
SS=C Bldg. 01	•	Maintenance and Testing					
blug. 01	•	Maintenance and Testing rand standpipe systems					
	•	ted, and maintained in					
	accordance with N	IFPA 25, Standard for the					
		g, and Maintaining of					
		Protection Systems. n design, maintenance,					
		ting are maintained in a					
	secure location an	d readily available.					
	a) Date sprinkler	system last checked					
	b) Who provided	system test					
	c) Water system	supply source					
	Provide in REMAR	RKS information on					
	-	non-required or partial					
	automatic sprinkle	r system.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPL	
		155162	B. W	ING		07/12/	2024
	PROVIDER OR SUPPLIER		•	600 WA	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINED'S DLAN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	9.7.5, 9.7.7, 9.7.8,						
		on and interview, the facility	K 0	353	What corrective action(s) will I		07/31/2024
		ne automatic sprinkler systems			accomplished for those residents		
	in accordance with NFPA 25, Standard for the				found to have been affected b	y the	
		, and Maintaining of			deficient practice;		
	Water-based Fire Protection Systems. Section 13.3 requires control valves in water-based fire				Post Indicator Valve (PIV) sig	jht	
	_				glass replaced		
	1 -	to be normally open. Section l valves to be inspected weekly.			How other residents having th		
	This deficient practice could affect all residents,				How other residents having the potential to be affected by the		
	staff, and visitors in				same deficient practice will be		
	Starr, and visitors in	t the facility.			identified and what corrective	•	
	Findings include:				action(s) will be taken;		
	1 manigs metade.				All residents had the potentia	l to	
	Based on an observation and interviews during a				be affected by this deficient		
	tour of the facility v	with the Executive Director (ED)			practice. PIV valve was replace	ced.	
	and the Maintenanc	e Director from another					
	building (MD) on 0	7/12/24 between 11:50 a.m. and			What measures will be put into	0	
	2:15 p.m., the Post	Indicator Valve (PIV) located			place and what systemic char	nges	
	I -	had a sight glass on each side			will be made to ensure that the	е	
		ally indicate "OPEN".			deficient practice does not rec		
		on each side was so distorted			Sprinkler Contractor will inspe		
	from age that it cou	ld not be read.			PIV annually to ensure the op	en	
	TE1: C 1:	1 11 11 1 55 1			/closed indicator is visible.		
	_	knowledged by the ED and			Inspection will be documented	and	
	onference.	liscovery and again at the exit			stored in TELS.		
	Comerence.				How the corrective action(s) w	vill be	
	3.1-19(b)				monitored to ensure the defici		
	17(0)				practice will not recur, i.e., wh		
					quality assurance program wil		
					put into place		
					On going compliance with this	;	
					corrective action will be monite		
					via facility QAPI program, with	1	
					meetings being held every oth	ner	
					month. And overseen by the		
					Executive Director. The		
					Maintenance Director or desig		
					will document the inspection of	of the	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/12/2024	
	PROVIDER OR SUPPLIER		600	EET ADDRESS, CITY, STATE, ZIP COD WASHINGTON AVE BASH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION DATE	
K 0361 SS=E Bldg. 01	NFPA 101 Corridors - Areas Corridors - Areas Spaces (other that treatment rooms a waiting areas, nur and cooking facilit in accordance wit and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on observatif failed to ensure 1 o quantity of combus corridor was not us 19.3.6.1(7) states th sleeping rooms, treareas shall be open in area, provided: (a which the space op- compartment are provided to the space op- compartment are provided.	Open to Corridor Open to Corridor n patient sleeping rooms, and hazardous areas), se's stations, gift shops, sies, open to the corridor are in the criteria under 18.3.6.1 on and interview, the facility of 3 alcoves with a large tible material open to the ed as hazardous storage. LSC that spaces other than patient atment rooms, and hazardous to the corridor and unlimited a) The space and corridors ens onto in the same smoke totected by an electrically	K 0361	PIV in the TELS. If 100% compliance is not achieved, a action plan will be developed. By what date the systemic changes for each deficiency be completed. After submittin acceptable Plan of Correction is determined that the correct will not be completed by the opreviously submitted, The Dinneeds to be contacted as soo possible. The facility will need submit an amended plan of correction with the updated procrection date. 7/31/24 What corrective action(s) will accomplished for those resid found to have been affected deficient practice; Lounge cleaned of all combumaterials How other residents having the potential to be affected by the same deficient practice will be same deficient practice.	be of the stible	
	supervised automat	otected by an electrically ic smoke detection system in .3.4, and (b) Each space is		same deficient practice will be identified and what corrective action(s) will be taken;		

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AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER 155162	A. BUILDING B. WING	01	COMPLETED 07/12/2024		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	protected by an auto space does not to obe exits. This deficien and residents. Findings include: Based on an observatour of the facility wand the Maintenanc building (MD) on 0 2:15 p.m., the secon corridor was being a several boxes and a combustible materia. This finding was according to the second of the	pomatic sprinklers, and (c) The estruct access to required at practice could affect 15 staff ation and interviews during a with the Executive Director (ED) are Director from another 7/12/24 between 11:50 a.m. and d-floor lounge, open to the used as storage containing pallet along with other		All residents had the potential be affected by this deficient practice The Maintenance Dir or designee will complete an in-house audit of all lounges the ensure they are clear of combustible materials to ensure their compliance. What measures will be put into place and what systemic charnwill be made to ensure that the deficient practice does not read Staff inserviced to keep loung areas cleaned of combustible materials by ED/Designee. Maintenance Director will round weekly to ensure lounges do have any combustible material located in the lounge area. How the corrective action(s) we monitored to ensure the deficing practice will not recur, i.e., who quality assurance program with put into place. On-going compliance with this corrective action will be monit via facility QAPI program, with meetings being held every oth month, and overseen by the Executive Director. The Maintenance Director or designing will document the Areas Oper Corridors K361 tool weekly xamonthly x6, and quarterly the after until compliance is achief 100% compliance is not achieved an action plan will be developed.	to ector o ector o ore o ore o ore o ore o ore o ore o o ore o o o o		

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	OF CORRECTION	IDENTIFICATION NUMBER 155162	A. BUILDING B. WING	01	COMPLETED 07/12/2024
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 DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K 0363 SS=E Bldg. 01	than required enclexits, or hazardous of smoke and are solid-bonded core capable of resistin minutes. Doors in compartments are passage of smoke to rooms containing combustible mater hardware. Roller la CMS regulation. The apply to auxiliary solid flammable or combustible covering is not except to the door closed with a containing the covering is not except to the door closed with applied. There is the solid flammable or combustible materials.	wood or other material g fire for at least 20 fully sprinklered smoke only required to resist the . Corridor doors and doors g flammable or ials have positive latching atches are prohibited by hese requirements do not		By what date the systemic changes for each deficiency who completed. After submitting acceptable Plan of Corrections is determined that the correctivill not be completed by the dipreviously submitted, The Divinceds to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated plat correction date. 7/15/24	g an if it on ate sion n as to

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE C A. BUILDING B. WING	onstruction ((X3) DATE SURVEY COMPLETED 07/12/2024	
	PROVIDER OR SUPPLIEIN RIDGE REHABIL		600 W	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 DEFICIENCY)	(X5) COMPLETION DATE	
	permitted. Nonrat unlimited height a meeting 19.3.6.3. frames shall be la other materials in unless the smoke sprinklered. Fixed allowed per 8.3. In there are no restr resistance of glass assemblies. 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratic devices, etc. Based on observatifailed to ensure 1 of impediment to closs frame and would residents. Findings include: Based on an observation of the facility of the facility and the Maintenand building (MD) on (2:15 p.m., Resident positively into the case of the finding was accomplished.	door is pushed or pulled are ed protective plates of re permitted. Dutch doors 6 are permitted. Dutch doors 6 are permitted. Door beled and made of steel or compliance with 8.3, compartment is 1 fire window assemblies are in sprinklered compartments ictions in area or fire is or frames in window. Parts 403, 418, 460, 482, 483 details of doors such as ings, automatics closing on and interview, the facility if over 20 corridor doors had no ing and latching into the door exist the passage of smoke. Since could affect 6 staff and 6 in a with the Executive Director (ED) are Director from another 17/12/24 between 11:50 a.m. and at Room #304 failed to latch door frame when tested at east exhausted by the ED and discovery and again at the exit	K 0363	What corrective action(s) will be accomplished for those resident found to have been affected by deficient practice; RR #304 repaired to latch 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; Any Resident in this room had to potential to be affected by this deficient practice What measures will be put into place and what systemic change will be made to ensure that the deficient practice does not recurred. The maintenance Director or designee will complete an	tts the the	

3.1-19(b)

in-house audit of all resident doors

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-039	
· ·		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	A. BU) MULTIPLE CONSTRUCTION BUILDING WING		(X3) DATE SURVEY COMPLETED 07/12/2024	
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 DEFICIEN	STATEMENT OF DEFICIENCIE CY 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 APPROPRIAT DEFICIENCY) to ensure they latch and ensur further compliance. How the corrective action(s) w monitored to ensure the deficie practice will not recur, i.e., wha quality assurance program will put into place On going compliance with this corrective action will be monito via facility QAPI program, with meetings being held every othe month. And overseen by the	re ill be ent at l be pred	(X5) COMPLETION DATE
					Executive Director. The Maintenance Director or design will document on the Doors K3 QAPI tool weekly x4, monthly and quarterly there after until compliance is achieved. By what date the systemic changes for each deficiency who be completed. After submitting acceptable Plan of Correction, is determined that the correction will not be completed by the dapreviously submitted, The Divisioneeds to be contacted as soon possible. The facility will need submit an amended plan of correction with the updated plat correction date. 7/15/24	ill y an if it on ate sion n as to	
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include	the transmission of a fire					

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Event ID:

alarm signal and simulation of emergency fire conditions. Fire drills are held at expected

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Facility ID: 000081

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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. BU				COMPLETED	
		155162	B. W	B. WING		07/12/2024		
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF 1	PROVIDER OR SUPPLIEI	R			ASHINGTON AVE			
AUTUM	N RIDGE REHABILI	ITATION CENTRE		WABASH, IN 46992				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		imes under varying						
	· ·	st quarterly on each shift.						
		ar with procedures and is						
		re part of established						
		rills are conducted between						
	9:00 PM and 6:00							
		ay be used instead of						
	audible alarms. 19.7.1.4 through	10 7 1 7						
		view and interview, the facility	K 0	712	What corrective action(s) will	he	07/31/2024	
		re drills on each shift for 1 of 4	K U	114	accomplished for those reside		07/31/2024	
		.1.6 states drills shall be			found to have been affected b			
	_	y on each shift to familiarize			deficient practice;	by the		
		nurses, interns, maintenance			New Maintenance Director			
		ninistrative staff) with the			inserviced on Fire			
	_	ency action required under			drills/documentation			
	varied conditions.	This deficient practice affects						
	all staff and residen	nts.			How other residents having th	ne		
					potential to be affected by the	;		
	Findings include:				same deficient practice will be	Э		
					identified and what corrective			
		eview and interviews with the			action(s) will be taken;			
		(ED) and the Maintenance			All residents had the potential	l to		
		her building (MD) on 07/12/24			be affected by this deficient			
		and 11:50 a.m., the following			practice. New maintenance			
	1	documentation of a completed			director was inserviced on fire	9	1	
	fire drill:	ire drill in the fourth quarter of			drills/documentation			
	2023.	ne ann in the fourth quarter of			What measures will be put int	to		
		drill in the fourth quarter of			place and what systemic char			
	2023.	arm in the routin quarter or			will be made to ensure that th	-		
	2023.				deficient practice does not rec			
	Based on interview	at the time of record review,			Maintenance director will com		1	
	both ED and MD stated the drills were likely not				fire drills each quarter on diffe	•		
		lity was missing a Maintenance			shifts, this will be reviewed by			
	person about that ti	-			, , , , , , , , , , , , , , , , , , , ,			
	1				How the corrective action(s) v	will be		
	This finding was ac	cknowledged by the ED and			monitored to ensure the defic			
	MD at the time of o	discovery and again at the exit			practice will not recur, i.e., wh	nat		
	conference.				quality assurance program wi			

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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 07/12/2024		
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 DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	3.1-19(b)			put into place On going compliance with thi corrective action will be monivia facility QAPI program, wit meetings being held every of month. And overseen by the Executive Director. The Maintenance Director or desivill document fire drills in the TELS. If 100% compliance is achieved, an action plan will developed. By what date the systemic changes for each deficiency be completed. After submittin acceptable Plan of Correction is determined that the correct will not be completed by the previously submitted, The Dineeds to be contacted as so possible. The facility will need submit an amended plan of correction with the updated procurection date. 7/31/24	tored h her gnee not be will ag an h, if it tion date vision on as d to		

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