	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	onstruction 00	(X3) DATE SURVEY COMPLETED	
		155162	B. WING		04/12/2021	
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE ASHINGTON AVE		
AUTUM	N RIDGE REHABIL	ITATION CENTRE		SH, IN 46992		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY	DATE	
Bldg. 00						
Diug. 00	This visit was for	the Investigation of Complaints	F 0000	The creation of and submissi	on of	
		s visit resulted in a Partially	1 0000	this plan of correction does n		
		Substandard Quality of Care -		constitute admission by this		
	Immediate Jeopare	ły.		provider of any conclusion se forth in the statement of	t	
	Complaint IN0035	51093 - Substantiated.		deficiencies, or of any violation	ons	
		eiencies related to the		of regulation. This provider		
	allegations are cite	ed at F689 and F803.		respectfully requests that the		
	Survey dates: Apr	il 8, 9, 10, 11 and 12, 2021.		plan of correction be conside the letter of credible allegatio	n and	
	Facility number: 0	00081		request a post survey review after 4/30/21 . We respectfull		
	Provider number:			request a desk review in lieu	-	
	AIM number: 100			post survey revisit.		
	Census Bed Type:					
	SNF/NF: 56 Total: 56					
	Census Payor Typ	e:				
	Medicare: 9					
	Medicaid: 39					
	Other: 8					
	Total: 56					
	These deficiencies	reflect State Findings cited in				
	accordance with 4	0				
	Quality review con	mpleted on April 15, 2021.				
0689	483.25(d)(1)(2)					
SS=J	Free of Accident					
Bldg. 00	Hazards/Supervi					
	§483.25(d) Accio The facility must					
		e resident environment				
		of accident hazards as is				

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

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Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

	R MEDICARE & MEDIONT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	ILTIPLE C	ONSTRUCTION	(X3) DATE	IB NO. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
IND PLAN	OF CORRECTION	<u></u>		00			
		155162	B. WI	NG		04/12/2021	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
AUTUM	N RIDGE REHABIL	ITATION CENTRE			ASHINGTON AVE SH, IN 46992		
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIES ID				(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	possible; and						
	8483 25(d)(2)Ea	ch resident receives					
		ision and assistance devices					
	to prevent accide						
		eview and interview the facility	F 06	89	F 689 – Free of Accident		04/30/2021
		resident with dysphagia and at	1.00		Hazards/Supervision/Devices	;	07/30/2023
		ceived supervision while			It is the practice of this provide		
	Ũ	esidents at risk for choking.			ensure the resident environme		
	-	tice resulted in the resident			remains as free of accident		
	·	d the emergency services being		hazards as is possible, and eac			
	-	dent hospitalized. The resident			that each resident receives		
		021. (Resident B).			adequate supervision and		
		ozi. (Resident D).			assistance devices to prevent		
	The immediate iec	pardy began on 4/5/21 when a			accidents.		
	-	ed Resident B a tray of food			What corrective action(s) will		
		nt with no assistance or			be accomplished for those		
		Administrator and Nurse			residents found to have been		
	-	otified of the immediate			affected by the deficient		
		.m. on April 9, 2021. The			practice:		
		ly was removed on $4/11/21$ ,			Resident B no longer resides a	at	
	U 1	e remained at the lower scope			the facility.		
	-	of isolated, no actual harm with			How other residents having the	ho	
	•	than minimal harm that is not			potential to be affected by the		
	immediate jeopard				same deficient practice will be		
	ininicalate jeopare	·y ·			identified and what corrective		
	Findings include:				action(s) will be taken:	•	
	i manigs metade.				• Any residents who require	re	
	Resident R's clinic	al record was reviewed on			supervision while eating have t		
		. Diagnoses included, but were			potential to be affected by this		
		pecified intellectual			finding.		
		ntellectual disabilities,			· Speech Therapy will		
		itia without behavioral			screen all residents who are		
	<u>^</u>	elated cognitive decline,			coded as total dependent,		
	-	astro-esophageal reflux			extensive assist, limited assist,		
		ophagitis, dysphagia,			and supervision for eating and		
		esophageal and dysphagia,			recommend level of supervision		
	oropharyngeal pha				during meals. These screens w		
	oropharyngear pha	ioc.			be completed on or before	V1/1	
		d but want a st limited to					

Her orders included, but were not limited to,

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011 Facility I

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155162 B. WING 04/12/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE WABASH. IN 46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) consistent carbohydrate, mechanical soft, ground Care plans and resident meat, special instructions: Kennedy cups (a spill profiles will be updated to reflect the required need of supervision proof cup with lid) and divided plate with meals during resident meals per ST started on 2/12/21 and speech therapist to treat recommendations. These were three times week for eight weeks for oropharyngeal dysphagia treatment will include completed by 4/11/21. Inservice all staff per restorative exercise, compensatory strategy training, and staff/caregiver as indicated started Executive Director/Designee by 4/11/21. Inservice to cover ONLY on 01/19/2021. nursing to order resident meal A 5-day admission Minimum Data Set (MDS) trays from Culinary and required assessment, dated 1/21/21, indicated the resident supervision for residents during was moderately cognitively impaired. She resident meals. required extensive assistance of one staff What measures will be member for eating. She required a therapeutic put into place or what systemic diet and she had no swallowing disorders. She changes will be made to ensure had no natural teeth or tooth fragment(s) that the deficient practice does not recur: (edentulous). Inservice all staff per A physician evaluation and management report Executive Director/Designee by 4/11/21. Inservice to cover ONLY for a swallow study performed on 1/26/21 indicated the resident was seen due to problems nursing to order resident meal trays from Culinary and required with eating and drinking. The diet recommendations were to give pills, one at a supervision for residents during resident meals. time in puree carrier. The following actions were recommended regarding the patient's feeding: Residents who require supervision for eating will be small bites/sips, alternate bites/sips, precautions during mouth feeding: speech language therapist encouraged to eat each meal in the Assist Dining room. This was and trained staff only, small bites/sips, cueing for strategies: allow extra time, aspiration initiated on 4/11/21. precautions: monitor for pulmonary status, Nursing department will be reflux precautions: head of bed no lower than 45 completing a supervision log for degrees all other times, upright at 90 degrees each meal that signifies the Nurse or designee provided supervision during by mouth and 45 minutes after meals, monitor patient for adequate nutrition and for meal service through the entirety of the meal. This was hydration. initiated on 4/11/21. A 2/3/21 reviewed/revised care plan indicated Speech Therapy will the resident was at risk for aspiration related to screen all new diagnosis of dysphagia. Her goal was that she admissions/readmissions, and all

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155162 B. WING 04/12/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE WABASH. IN 46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) would be free from symptoms of aspiration. residents triggering for a diet Interventions included, but not limited to, diet as downgrade to identify the needed supervision during resident meals. ordered and observe for symptoms of aspiration, Speech Therapy will which included choking, frequent cough that complete the Therapy occurs before/during or after swallowing, runny nose while eating. Recommendation log and review with DNS/Designee during daily A diet order and communication form from clinical meeting. Resident care Speech Therapist 17, dated 2/8/21, indicated plan and profile will be updated there was a diet change, mechanical soft with thin during clinical meeting with liquids and needed divided plates and a Kennedy identified recommendation. How the corrective action(s) cup. will be monitored to ensure the A 2/18/21 reviewed/revised care plan for the deficient practice will not recur; resident required assistance with Activity of i.e., what quality assurance Daily Living(ADLs) including eating. program will be put into place: Interventions included, but were not limited to, ·Ongoing compliance with this may use divided plates and Kennedy cups with corrective action will be monitored meals, assist with eating and drinking as needed, through the facility QAPI assist with oral care at least two times daily, Program, with meetings being upper and lower dentures. held monthly and overseen by the Executive Director. A diet order and communication form from ·DNS or designee will document Speech Therapist 17, dated 3/10/21, indicated a on the "Supervision during meals diet order for controlled carbohydrates, a QAPI Audit Tool" daily for 6 mechanical soft diet and she needed a divided weeks, weekly x 6 months, and plate and a two handled spout cup. monthly thereafter until compliance is achieved. ·If threshold of 100% is not met, A Speech Therapist progress note, dated 4/1/21, indicated Impact on Burden of Care/Daily Life: an action plan will be developed. the patient continued to require set up assist Findings will be submitted to the prior to and supervision during intake. Patient QAPI Committee for review and required set up assist for bolus size follow up. By what date the systemic modifications, large food items to be cut to bite-size due to decreased safety awareness, changes will be completed: decreased safety judgement, and poor ability to Compliance Date = 4/30/21 bite due to edentulous status. Due to impulsivity and poor safety judgement, she required verbal cues to slow rate of intake, finish one bolus prior to initiating another. She continued to require

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155162 B. WING 04/12/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE WABASH, IN 46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) modified diet of mechanical soft secondary to poor ability to masticate, poor oral control, poor lingual coordination and Base of Tongue (BOT) strength, poor pharyngeal constriction. She continued to require adaptive equipment i.e. spout cup or Provale cup to facilitate rate of liquid intake. She continued to require handled cup and divided plate to facilitate self-feeding. She continued to require reflux precautions secondary to esophageal reflux and retention. Precautions: Supervise by mouth intake, soft diet, cut foods to bite-size, poor safety awareness, poor recall, high fall risk, weight bearing as tolerated for her left lower extremity. A nurse's note, dated 4/5/21 at 1:45 p.m., indicated the resident was in the dining room eating when a CNA noted the resident choking, the Heimlich was performed at that time, a finger sweep was performed three times and was unsuccessful. The resident was moved to her room at that time Cardiopulmonary Resuscitation (CPR) was initiated and 911 was called. On 4/5/21 at 1:58 p.m., the local fire department was at the facility and CPR continued. On 4/5/21 at 2:17 p.m., the local fire department (Emergency Management Team) EMTs continued with CPR, pulse and respiration was revived. Resident was transported to a local hospital's emergency room. During an interview with Dietary Cook 15, on 4/8/21 at 11:14 a.m., she indicated on 4/5/21 someone had called down to the kitchen and requested a peanut butter and jelly sandwich because the resident didn't like what she had on her tray. She prepared the peanut butter and jelly FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: P6D011 Facility ID: 000081 If continuation sheet Page 5 of 23

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(V2) MUI	TIDI E CON	NSTRUCTION	(X3) DATE	SUDVEV
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL		00	COMPI	
	or conduction	155162	B. WING		00	04/12	
			<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			SHINGTON AVE		
AUTUM	N RIDGE REHABIL	ITATION CENTRE		WABASI	H, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
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TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		a, an oatmeal creme pie and a					
		l took the tray upstairs,					
	Activity Aide 21 v	vas in the dining room with					
		indicated she thought the					
	resident had alread	ly ate, Dietary Cook 15					
	indicated to Activi	ty Aide 21 that the resident					
		as on her tray and she placed the					
	tray in front of the	resident.					
	During an intervie	w, on 4/8/2021 at 11:28 a.m.,					
	U U	l she was passing medication					
		As said the resident was					
		went to the dining room and					
		naneuver on her while she was					
		and told the CNA to get the					
		V came to the dining room.					
		ssessment on the resident and					
		m, then QMA 12 grabbed					
		lies and other supplies the					
		was unaware if anyone was in					
		e resident when she started					
	Ũ	he was passing down the hall					
	-	office. One of kitchen staff					
		t butter and jelly sandwich up to					
		se she didn't care for the food					
	they had that day.	se she didii t care for the food					
	-	w, on 4/8/21 at 11:35 a.m.,					
		the CNAs were in and out of					
		bing weights because Resident					
		. She didn't know who called					
		n and asked for the sandwich.					
		vith her, the resident could feed					
		d set her up, get her started and					
	she would do it he	rself.					
	During an intervie	w, on 4/8/21 at 12:00 p.m.,					
		17, indicated the resident was					
		ne was working with her on rate					
		she liked to eat quickly and not					
		1 2					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		DNSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155162	A. BUILDING <u>00</u> B. WING		00	COMPLETED 04/12/2021	
NAME OF				STREET A	ADDRESS, CITY, STATE, ZIP	CODE	
NAME OF	PROVIDER OR SUPPLIE	IK		600 WA	SHINGTON AVE		
AUTUM	N RIDGE REHABIL	ITATION CENTRE		WABAS	SH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	OPPECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETIC
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	finish the bite in h	er mouth before she took					
	another bite. She r	eeded verbal and tactile cues,					
	she followed verba	al cues well. She was also					
	working on taking	smaller bites and smaller					
	drinks, she was no	t cognitively aware of safety					
	and her fine motor	skills were not great. She had					
		er on the day she choked. She					
	had recommended	supervision in the resident's					
		the swallow study					
		ervision also. She did verbal					
		nursing staff and reviewed the					
		from the swallow study a					
		but there had been a lot of					
		en and didn't know if it got					
		vorked with peanut butter and					
		lent and would cut it up for her					
		, she didn't feel it was safe for					
	her to eat unsuperv	vised.					
	During an intervie	w, on 4/8/21 at 2:01 p.m.,					
	-	34, indicated he completed an					
		le in the dining room on third					
		ame area as Resident B had					
	choked. He had gl	anced over and noticed					
	Resident B started	to choke and the CNAs were					
	standing in the hal	lway behind the resident. He					
	ran to the nurse wh	no was standing at the					
	medication cart an	d told her the patient was					
	choking and she st	arted doing the Heimlich					
	maneuver on the r	esident. She was not purple,					
	she was starting to	choke.					
	A review of the ho	ospital notes on 4/9/21 at 9:30					
	a.m. indicated the						
		lonowing.					
	History of Present	Illness (HPI) dated 4/5/21					
		pital Emergency Room (ER)					
		ent presented emergency					
		post respiratory and					
		c arrest. She had multiple					

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FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 155162 B. WING 04/12/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE WABASH, IN 46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) DATE p.m., indicated the event that lead to death was the patient choked on a peanut butter sandwich and then cardiac arrest. Diagnosis was cardiac arrest. Date and time of death was 4/8/21 at 6:54 p.m. During an interview with the Administrator and the Nurse Consultant, on 4/9/21 at 2:34 p.m., the Administrator indicated a housekeeper had called down to the kitchen to order the resident's food. A current facility policy, revised on 2/2015, titled "Deliver and Documentation of Meal Service and Between Meal Nourishments," provided by the Nurse Consultant on 4/8/21 at 3:00 p.m. indicated the following: "...PROCEDURE, Delivery, The Nursing Department with the assistance of the Dietary Department will be responsible for the delivery of meals and nourishments and ensuring that all efforts are made to assist residents during meal and nourishment times. The Licensed Nurse is responsible for the supervision and coordination of CNAs during these daily activities...Specific mealtime responsibilities are: Provide assistance needed for meal set up (i.e. buttering bread, opening condiment packages, opening removing covers on foods and beverages). Assist residents in eating as needed ... Review tray identification card...Substitutes for Food Refusals...Substitutes should be offered which are within the parameters of any therapeutic diet order...In the event that a resident consistently will accept only substitutes which are outside the parameters of the diet order, the Dietary Manger or Registered Dietitian will offer diet instruction and the benefits of the special diet to the resident's overall health. This will be documented in the medical record ..... " FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: P6D011 Facility ID: 000081 If continuation sheet Page 9 of 23

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construction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/12/2021	
T ADDRESS, CITY, STATE, ZIP CO	DDE	
VASHINGTON AVE ASH, IN 46992		
PROVIDER'S PLAN OF CORRE	ECTION (X5)	
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DEFICIENCY)	DATE	
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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155162	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/12/2021	
	PROVIDER OR SUPPLIER 600 WASHIN		ADDRESS, CITY, STATE, ZIP CODE ASHINGTON AVE SH, IN 46992	HINGTON AVE		
(X4) ID PREFIX TAG	(EACH DEFICIE)	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	dietitian or other of professional for m §483.60(c)(7) No should be constru- right to make per Based on record re failed to ensure a r risk for choking re form for 1 of 4 resi- choking. This defice resident choking, c services being call. The resident later of B). The immediate jeo Dietary Aide server that was not in the resident to eat. The Consultant were no jeopardy at 1:11 p. immediate jeopard but noncompliance and severity level of isolated, nu for more than mini immediate jeopard Findings include: Resident B's clinic 4/8/21 at 9:58 a.m. not limited to, unsy disabilities, other i unspecified demen disturbance, age-re bipolar disorder, ge	reviewed by the facility's clinically qualified nutrition utritional adequacy; and thing in this paragraph ued to limit the resident's sonal dietary choices. view and interview the facility esident with dysphagia and at ceived a diet in the correct dents reviewed for a risk of cient practice resulted in the oding and the emergency ed and resident hospitalized. lied on 4/8/2021. (Resident pardy began on 4/5/21 when a d Resident B a tray of food correct form and left the e Administrator and Nurse otified of the immediate m. on April 9, 2021. The y was removed on 4/11/21, e remained at the lower scope to actual harm with potential mal harm that is not y.	F 0803	<ul> <li>F803 – Menus meet resident needs/prep in advance/follow It is the intent of this provider all residents will receive food accordance with state and fe guidelines regarding menus, prep, and nutritional value.</li> <li>What corrective action(s) w be accomplished for those residents found to have bee affected by the deficient practice: Resident B no longer resides the facility.</li> <li>How other residents having potential to be affected by t same deficient practice will identified and what correctifi action(s) will be taken: <ul> <li>Any resident who has a altered diet (i.e pureed, mechanical soft, thickened liquids) has the potential to b affected they the deficient practice.</li> <li>An in-service for all stat was completed by 4/12/21 pe Executive Director/Designee serving the appropriate meal/proper form per order a well as ordering food for residents.</li> </ul> </li> </ul>	red: that in deral food ill en the he be ve un e ff er on	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

P6D011

Facility ID: 000081

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**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 155162 B. WING 04/12/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE WABASH. IN 46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) esophageal and dysphagia, oropharyngeal phase. \*A facility-wide audit of all resident diet orders and proper form was completed by the Her orders included, but were not limited to, CM/designee on 4/10/21. consistent carbohydrate, mechanical soft, ground Resident tray cards were updated meat, special instructions included to use Kennedy cups (a spill proof cup with lid) and with any changes noted during the tray card audit on 4/11/21. divided plate with meals started on 2/12/21 and the speech therapist was to treat three times week for eight weeks for oropharyngeal Any residents identified with any altered diet will be dysphagia (the inability to initiate swallowing). The treatment would include restorative screened by Speech Therapy to exercise, compensatory strategy training, and ensure proper form is being staff/caregiver as indicated started on served/ordered. This was 01/19/2021. completed on 4/11/21. All care plans and resident A 5-day admission Minimum Data Set (MDS) profiles were updated to reflect assessment, dated 1/21/21, indicated the resident the proper form/diet. This was completed on 4/11/21. was moderately cognitively impaired. She required extensive assistance of one staff \* Resident tray cards were member for eating. She required a therapeutic updated on 4/11/21 by CM to diet and she had no swallowing disorders. She reflect any changes to a had no natural teeth or tooth fragment(s) resident's diet to ensure trav card reflected the ordered diet in (edentulous). proper form. There were no A physician evaluation and management report resident's whose diet order/form for a swallow study performed on 1/26/21 did not match the tray cards. indicated the resident was seen due to problems with eating and drinking. The diet What measures will be put into place or what systemic recommendations were to give pills, one at a time in puree carrier. Meat diet was to be changes will be made to ensure mechanical soft (all solids ground) and thin that the deficient practice does liquids. The following actions were not recur: recommended regarding the patient's feeding: a. small bites/sips In-service for all staff per b. alternate bites/sips Executive Director/Designee was completed on or by 4/12/21 on Precautions during mouth feeding included: serving the appropriate a. speech language therapist and trained staff only meal/proper form per order as b. small bites/sips well as ordering food for residents.

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If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION (,	X3) DATE SURVEY COMPLETED
	of condenion	155162	B. WING	<u> </u>	04/12/2021
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
	N RIDGE REHABIL	ITATION CENTRE		ASHINGTON AVE SH, IN 46992	
X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID			PROVIDER'S PLAN OF CORRECTION	(X5)
REFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Cueing strategies i			<ul> <li>*Resident's tray cards w</li> </ul>	ill
	a. allow extra time	;		be monitored for each meal by	
				Culinary Cook to ensure the	
		ommunication form from the		proper diet/form is served.	
		(ST) 17, dated 2/8/21,		* * Resident tray cards will	
		s a diet change, the resident		be updated when there is a	
		hanical soft diet with thin		change of diet/form, and will be	
	liquids and needed	l divided plates and a Kennedy		audited by the Culinary Manage	
cup.	cup.			for each resident in accordance	;
				with their scheduled MDS	
		ommunication form from		assessment.	
		17, dated 3/10/21, indicated a		<ul> <li>Culinary Cooks will keep</li> </ul>	
	diet order for contr	rolled carbohydrates, a		log each meal to validate the tra	-
	mechanical soft di	et and she needed a divided		cards were monitored for prope	r
	plate and a two has	ndled spout cup.		diet/form.	
				DNS/Designee will roun	d
	A nurse's note, dat	ed 3/14/21 at 12:56 a.m.,		during each meal to ensure the	
		ent had behaviors that shift and		proper diet/form is served.	
		ies throughout the shift.		<ul> <li>Speech Therapy will</li> </ul>	
	Resident had been	given two cookies, fresh ice		screen all new	
	water, a strawberry	y ensure, and potato chips.		admissions/readmissions or	
				residents who experience a	
		ote, dated 4/1/21, indicated		change in condition related to	
	-	of Care/Daily Life: the patient		change in diet to determine the	
	-	re set up assist prior to and		proper food form the resident	
	-	intake. Patient required set up		should receive.	
		s size modifications, large		Only Nursing staff will ca	all
		at to bite-size due to		Culinary to notify them if a	
		wareness, decreased safety		resident is requesting somethin	g
		or ability to bite due to		different than what was on the	
		Due to impulsivity and poor		menu. The Culinary Cook will	
		she required verbal cues to		deliver the food to the member	
		, finish one bolus prior to		the Nursing team who ordered	the
	-	She continued to require		food.	
		echanical soft secondary to			
	-	sticate, poor oral control, poor		How the corrective action(s)	
		on and Base of Tongue (BOT)		will be monitored to ensure the	
		ryngeal constriction. She		deficient practice will not recu	ır,
		re adaptive equipment i.e.		i.e., what quality assurance	
	spout cup or Prova	ale cup to facilitate rate of		program will be put in place:	

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PRINTED: 05/10/2021 FORM APPROVED

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

PRINTED: 05/10/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155162	(X2) MULTIPLE C A. BUILDING B. WING	00	О4/1	e survey pleted 2/2021
	PROVIDER OR SUPPLIEI N RIDGE REHABILI		600 W	ADDRESS, CITY, STATE, ZIP CO ASHINGTON AVE SH, IN 46992	РDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
	cup and divided pla She continued to re- secondary to esoph Precautions: Super- diet, cut foods to bi awareness, poor red bearing as tolerated A nurse's note, data indicated the reside eating when a CNA the Heimlich was p sweep was perform unsuccessful. The r room at that time C called. On 4/5/21 at 1:58 p was at the facility a On 4/5/21 at 2:17 p Emergency Medica continued with CPI revived. Resident v hospital emergency A 4/6/21 reviewed/ resident indicated s dentures and was a due to use of dentu caring for dentures have clean, properl partial, assure that device v Observe for any ch During an interviev Dietary Manager, i	<ul> <li>call, high fall risk, weight</li> <li>l for her left lower extremity.</li> <li>cd 4/5/21 at 1:45 p.m., ent was in the dining room</li> <li>a noted the resident choking, erformed at that time, a finger</li> <li>ied three times and was</li> <li>resident was moved to her</li> <li>PR was initiated and 911 was</li> <li>o.m., the local fire department</li> <li>o.m., the local fire department</li> <li>o.m., the local fire department</li> <li>d. Technicians (EMTs)</li> <li>R, pulse and respiration was</li> <li>vas transported to a local</li> <li>room.</li> <li>revised care plan for the</li> <li>he utilized a full set of</li> <li>t risk for mouth pain/problems</li> <li>res and needed assistance in</li> <li>Her goal was that she would</li> <li>y fitting dentures/bridge or</li> <li>device was fitting properly and</li> <li>vas present before meals.</li> </ul>		<ul> <li>Ongoing compl with this corrective action monitoring through facilit Program, with being held monthly and by the Executive Director</li> <li>The "Proper Diet/F QAPI Tool" daily x 6 were weekly x 6 months, more thereafter until compliant achieved.</li> <li>If threshold of 2 not met, an action plant developed. Findings will submitted to</li> <li>the QAPI comment review and follow up.</li> <li>By what date the system changes will be completed Compliance date = 4/30</li> </ul>	n will be ity QAPI meetings overseen or. Form eks, athly ace is 100% is will be I be nittee for <b>mic</b> eted:	

	R MEDICARE & MEDI		(V2) M		NETRICTION		MB NO. 0938-03 E SURVEY
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í	ЛLDING	ONSTRUCTION	( - )	E SURVEY PLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU B. WI		00		
		155162	D. W1			04/1.	2/2021
NAME OF	PROVIDER OR SUPPLII	ER			ADDRESS, CITY, STATE, ZIP CODI	Ξ	
					ASHINGTON AVE		
AUTUMI	N RIDGE REHABII	LITATION CENTRE		WABAS	SH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	COMPLETI
TAG		OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	lisbury steak would be served					
		as would be pureed due to the					
		utter and jelly sandwich would					
		echanical soft. On 4/5/21 a					
		the therapist, called the					
		for the sandwich. The kitchen					
		e sandwich to the third floor.					
		should have looked at the diet					
	order first before	taking to the third floor.					
	During an intervie	ew with Dietary Cook 15, on					
	-	m., she indicated on $4/5/21$ the					
		d bean soup for lunch and					
		ed down to the kitchen and					
	requested a peanu	t butter and jelly sandwich					
		ent didn't like what she had on					
	her tray. She prep	ared the peanut butter and jelly					
	sandwich, a banar	a, an oatmeal creme pie and a					
	chocolate milk an	d took the tray upstairs,					
		was in the dining room with					
		indicated she thought the					
		dy eaten, Dietary Cook 15					
		ity Aide 21 that the resident					
		as on her tray and she placed the					
	-	e resident. Dietary Cook 15					
		was soft and appropriate for					
		hanical soft diet. On her ticket					
		sident had a mechanical soft					
		plate because she doesn't like , it did not indicate to cut up					
	-	ot uncommon for the staff to					
		d ask for a sandwich and she					
		at they requested to the					
	resident.						
	During an intervie	ew, on 4/8/21 at 11:28 a.m.,					
	QMA 12 indicated	d she was passing medication					
		As said the resident was					
		went to the dining room and					
	did the Heimlich	naneuver on her while she was					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 00 B. WING 155162 04/12/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 600 WASHINGTON AVE AUTUMN RIDGE REHABILITATION CENTRE WABASH, IN 46992 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) in her wheelchair and told the CNA to get the nurse and the DON came to the dining room. The DON did an assessment on the resident and took her to her room, then QMA 12 grabbed some oxygen supplies and other supplies the DON needed. She was unaware if anyone was in the lounge with the resident when she started choking because she was passing medication down the hall where the DON's office was located. One of kitchen staff brought the peanut butter and jelly sandwich up to the resident because she didn't care for the food they had that day. She had seen the dentures in the resident's room before and she thought the resident needed set up assistance for eating. During an interview on 4/8/21 at 11:35 a.m., CNA 29 indicated that on the day Resident B choked, the nurse instructed them to weigh the residents and that they needed to make a few beds. They weighed the residents in a closet in the dining room. CNA 22 and herself were taking turns weighing the residents. Lunch was over, they assisted the residents that needed assistance with eating and picked up all the trays in the dining room and down the halls including Resident B's meal tray. Dietary Cook 15 took the sandwich to Resident B's room and another CNA was making Resident B's roommates' bed and indicated to Dietary Cook 15 that Resident B was in the dining room and she had just finished lunch and that was why everyone was confused because she had already eaten. CNAs were in and out of the dining room doing weights because Resident B was done eating. She didn't know who called down to the kitchen asking for the sandwich. The resident wore dentures and refused them often and she was offered dentures in the morning. CNA 22 did put her dentures in that morning because when she went in to collect linens after FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: P6D011 Facility ID: 000081 If continuation sheet Page 16 of 23

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155162	(X2) MULTIPLE ( A. BUILDING B. WING	construction 00	COl	(X3) DATE SURVEY COMPLETED 04/12/2021	
NAME OF	PROVIDER OR SUPPLII	ER	STREET ADDRESS, CITY, STATE, ZIP CODE				
	N RIDGE REHABII	LITATION CENTRE		ASHINGTON AVE ASH, IN 46992			
	-						
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PREFIX	,	ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	E APPROPRIATE	COMPLETIC	
TAG		OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
		ed morning care, CNA 22 was					
		res and had put them in her					
		ncident she thought they found					
		ure in her room in the denture					
		ked with her, the resident could					
		would set her up, get her					
	started and she wo	ould do it herself.					
	During an intervie	ew on 4/8/21 at 12:00 p.m., The					
	Speech Therapist	17, indicated the resident was					
	on her caseload, s	he was working with her on rate					
	of intake because	she liked to eat quickly and not					
	finish the bite in h	er mouth before she took					
	another bite. She	needed verbal and tactile cues,					
	she followed verb	al cues well. She was also					
	working on taking	g smaller bites and smaller					
	drinks, she was no	ot cognitively aware of safety					
	and her fine motor	r skills were not great. She had					
		er on the day she choked. She					
		he resident to wear her dentures					
		was when she first did her					
		e had worked with the resident					
		for the last two months. The					
		ke her denture and they didn't					
	8	oss. She offered the resident					
		she refused and said she didn't					
		in. She had recommended					
	-	resident's progress notes and					
		recommended supervision					
		al education with the nursing					
		the recommendations from					
	-	a couple months ago but there					
		new staff since then and didn't					
	-	ied over. She worked with					
	-	jelly with the resident and					
	_	r her and cued her, she didn't					
	feel it was safe for	r her to eat unsupervised.					
		e interview with the resident's					
	nurse at the hospit	tal, on 4/8/21 at 1:22 p.m., she					

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155162	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING CETREET ADDRESS. CIEV. STATE. ZIE CODE		CON 04/	(X3) DATE SURVEY COMPLETED 04/12/2021	
	PROVIDER OR SUPPLIER			600 WA	ADDRESS, CITY, STATE, ZIP ASHINGTON AVE SH, IN 46992	CODE		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO	DRECTION	(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
		nt was being terminally ntilator at 3:00 p.m.						
	During an interview	on 4/8/21 at 2:01 p.m.,						
	Physical Therapist 3	34, indicated he completed an						
	evaluation at a table	in the dining room on third						
	floor around the sar	ne area as Resident B had						
	-	nced over and noticed						
		o choke and the CNAs were						
	-	way behind the resident. He						
		o was standing at the						
		told her the patient was						
	maneuver on the res	rted doing the Heimlich						
	maneuver on the res	sident.						
	A review of the hos a.m. indicated the fo	pital notes on 4/9/21 at 9:30 bllowing:						
	from the local hosp presented emergence respiratory and sub- had multiple medica unresponsive. First pulseless and starter protocol. She was a She had a few round minutes of chest con	t Illness (HPI), dated 4/5/21 ital ER indicated the resident y department status post sequent cardiac arrest. She al problems. She was found responder found her d CPR. She had full ACLS pparently found in asystole. ds of epinephrine and about 20 mpressions. She was						
	intubated. She appa	rently had a large amount of						
	-	vich removed from her airway.						
		and was transported to the						
	ER.							
	4/5/21 from the loca resident was hydrativentilator. Antibioti pneumonia and urin required sedation an	a Making (MDM), dated al hospital ER indicated the ed and maintained on a cs were initiated for possible ary tract infection. She ad had a satisfactory blood ate at that time. She would be						

STATEME	T OF DEFICIENCIES	V1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIDI	ECONSTRUCTION	(V2) DA	TE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		
		155162	B. WING	G <u>00</u>		12/2021
			STR	EET ADDRESS, CITY, STATE	E. ZIP CODE	
NAME OF 1	PROVIDER OR SUPPLIE	R		WASHINGTON AVE	-,	
AUTUM	N RIDGE REHABIL	ITATION CENTRE	WA	BASH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED T	TO THE APPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIE	NCY)	DATE
		ger hospital and remained				
		ed during the emergency				
	department course					
	c. An assessment f	from the larger hospital, dated				
		he resident was orally				
		l gastric tube and her pupils				
		viated upward. She was slightly				
		eral upper lung fields. She was				
		hing, noted of mouth around				
	eyes, no response	to verbal stimuli.				
	d. A Communicati	on with Primary Treatment				
	Team from the lar	ger hospital, dated 4/8/21,				
	indicated the resid	ent's family was at bedside and				
	poor prognosis, co	mpleted hypothermia, EEG				
		vaveform with goals and				
		sionate extubation was				
		plans for compassionate				
	extubation sometin	ne that day.				
	e. A palliative care	e assessment completed on				
	4/8/21, indicated the resident's palliative					
	<b>^</b>	determined she was				
		ocesses progressing rapidly.				
		, her pupils were not reactive.				
		breath sounds and rhonci was				
	-	neezing. Bowel sounds were				
		had a urinary foley catheter.				
	-	sive, intubated with no rposeful movement.				
		-				
		dated 4/8/21 at 4:17 p.m.				
	indicated the resid	ent was extubated to room air.				
	g. A hospital prog	ress note, dated 4/8/21 at 6:54				
		resident's respirations had				
	ceased.	-				
	h. A hospital prog	ress note, dated 4/8/21 at 8:25				
		,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155162			(X3) DATE SURVEY COMPLETED 04/12/2021		
	PROVIDER OR SUPPLIE	R		600 WA	ADDRESS, CITY, STATE, ZIP ( ASHINGTON AVE SH, IN 46992	CODE	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S	HOULD BE	COMPLETI
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	DATE
	p.m., indicated the	e event that led to death was the					
	patient choked on	a peanut butter sandwich and					
	then cardiac arrest	. Diagnosis was cardiac arrest.					
	Date and time of d	leath was 4/8/21 at 6:54 p.m.					
	During an intervie	w with CNA 23, on 4/9/21 at					
	-	dicated Resident B was on					
	soften mechanical diet. They did not normally						
	feed the resident peanut butter and jelly, therapy						
	would give it to her, cut it up and watch her. The						
	resident did not normally didn't eat alone.						
	Sometimes the kitchen staff would deliver the						
	food directly to the resident. The day the resident						
	choked, she did not order any food and the other						
	two CNAs that were working said they didn't						
	order it, either. CNA 23 was observed during the						
	interview on the kiosk, she indicated to find the						
	diets for the residents, it would be on their						
	profile and on the meal tickets. She clicked on a						
	resident to find the diet and was unable to locate						
	the diet. Then she tried to look up another resident and with much searching she found his						
	diet. Then went back to the other resident to						
		meone would order food for a					
		en staff would take it directly					
		here were normally two or					
		rs in the dining room, they					
	were in and out of	the dining room weighing					
	residents that day	and the therapist was in there					
	but she was not av	vare the resident had a second					
	tray and was eating	g.					
	A current facility	policy, dated 9/1/13, titled					
	"PROTOCOL FOR ALTERED DIET						
		THICKENED LIQUIDS,"					
	provided by the A	dministrator on 4/8/21 at 1:17					
	p.m. indicated the	following: "Speech therapist					
	determine an alter	ed diet consistency and/or					
	thickened liquids a	are necessary: 1. Speech					
	Therapist to meet	with resident and/or					

	R MEDICARE & MEDI						
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED		
		155162	B. WING		04/12/2021		
NAME OF	PROVIDER OR SUPPLII	ER		T ADDRESS, CITY, STATE, ZIP C	CODE		
				600 WASHINGTON AVE			
AUTUM	N RIDGE REHABII	ITATION CENTRE	WABA	ASH, IN 46992			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE COMPLETI		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
	responsible party						
		to include: Reasons for the					
		tency and/or thickened liquids					
		/swallowing difficulties, risk					
		ks associated with not					
	e e	ommendation for the altered					
		nd/or thickened liquids. 2.					
		o complete Altered Diet					
	-	owledgement in MatrixAn					
		y diet is any diet consistency					
	-	r consistency - Mech Soft,					
	Ground or Choppe	ed Meat, Puree, etc"					
	A current facility	policy, revised on 2/2015,					
	titled "Deliver and	l Documentation of Meal					
	Service and Betwee	een Meal Nourishments,"					
		urse Consultant on 4/8/21 at					
	3:00 p.m. indicate	-					
		Delivery The Nursing					
	-	he assistance of the Dietary					
		e responsible for the delivery					
		ishments and ensuring that all					
		assist residents during meal					
		imes. The Licensed Nurse is					
		e supervision and coordination nese daily activitiesSpecific					
		bilities are: Provide assistance et up (i.e. buttering bread,					
		it packages, opening removing					
		nd beverages). Assist residents					
		dReview tray identification					
	-	for Food RefusalsSubstitutes					
		which are within the					
		therapeutic diet orderIn the					
		nt consistently will accept only					
		are outside the parameters of					
		Dietary Manger or Registered					
		r diet instruction and the					
		cial diet to the resident's					
	-	is will be documented in the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155162	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			COM	(X3) DATE SURVEY COMPLETED 04/12/2021	
NAME OF	PROVIDER OR SUPPLIE	ER			DDRESS, CITY, STATE, ZIP COD	Е		
					SHINGTON AVE			
AUTUM	N RIDGE REHABIL	ITATION CENTRE		WABAS	H, IN 46992			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF	LD BE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		ГAG	DEFICIENCY)		DATE	
	medical record "	,						
	Soft Diet," provide 4/9/21 at 9:34 p.m Manual, indicated mechanical soft on individual who ha textured foods, pe or worn teeth. The Pathologist) may of determine if the di not be appropriate for dysphagiaFo to chew breads, to cooked pasta or rie moistened with m tough meats, whol peanut butter or cl The Administrator	titled, "Mechanical or Dental ed by the Administrator on from the Indiana Diet the following: "Use: The e dental soft diet is for ve difficulty chewing regular rhaps due to ill fitting dentures e SLP (Speech Language evaluate the individual to det is appropriate. This diet may for individuals being treated bod allowed: Bread/grains: easy ast crackers, graham crackers, ce, hot cereal, dry cereal ilkFoods not allowed: dry le pieces of meat, bacon slices, neese by itself, hot dogs" e indicated at that time the not allowed but the soft bread d list.						
	Mechanically Alte Consultant on 4/9/ they were following following: Definit foods that are mec chopping, grinding easy to chew and s ground or minced pieces. Foods are easily form a bolu foods that are too should be avoided appropriate for inc chewing/swallowi speech-language p	d "National Dysphagia Diet ered," provided by the Nurse /21 at 2:34 p.m. and indicated ng, the document indicated the ion: This diet consists of thanically altered by blending, g, or mashing so that they are swallow. Meat pieces are and no larger that ¼-inch moist and soft textured to s. Foods in large chunks or hard to be chewed thoroughly . Indications: This diet is dividuals with dysphagia or ng issues as assessed by a bathologist. The chart indicated e recommended were soft						

NTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         155162		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 04/12/2021		
	PROVIDER OR SUPPLIE N RIDGE REHABIL		600 WA	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) pancakes, breads, sweet rolls, Danish pastries,		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	or ground to less th or sauceSmooth peanut butter, almo butter as tolerated,	mositened, blended, chopped nan 1/4-inch thick with syrup nut and seed butters, such as ond butter, and sunflower seed and ok if used in tolerated ings and sweetners, inclluding s and perserves"				
	was removed on 4/ educated staff rega meal/proper form p food for residents, orders and proper f identified with any the Speech Therap being served/order remained at at no a minimal harm beca	pardy that began on 4/5/21 (11/21 when the facility rding serving the appropriate per order as well as ordering an audit of all resident's diet form and resident's that altered diet was screened by y to ensure proper form was ed, but the noncompliance actual harm, but potential for ause all care plans and profiles and education and monitoring altered.				
	This Federal tag re IN00351093.	lates to complaint				
	3.1-21(a)(3)					

P6D011 Facility ID: 000081

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If continuation sheet Page 23 of 23

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