STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155162	A. BUILDING _____ B. WING _____	C 05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN RIDGE REHABILITATION CENTRE	**600 WASHINGTON AVE WABASH, IN 46992**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00379783.

Complaint IN00379783- Unsubstantiated due to lack of evidence.

Survey dates: May 17 and 18, 2022

Facility number: 000081
Provider number: 155162
AIM number: 100289570

Census Bed Type:
SNF/NF: 42
Total: 42

Census Payor Type:
Medicare: 1
Medicaid: 33
Other: 8
Total: 42

Autumn Ridge Rehabilitationn Centre was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00379783.

Quality review completed on May 20, 2022.

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