STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155162		IDENTIFICATION NUMBER	A. BUILDING CO		(X3) DATE SURVEY COMPLETED 06/15/2023
	ROVIDER 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
E 0000 Bldg	conducted by the Irraccordance with 42 Survey Date: 06/15 Facility Number: 06 Provider Number: 100 At this Emergency Ridge Rehabilitatio compliance with Er Requirements for M Participating Provid 483.73. The facility census of 36 at the	5/23 00081 .55162 289570 Preparedness survey, Autumn n Centre was found in mergency Preparedness Medicare and Medicaid ders and Suppliers, 42 CFR has a capacity of 75 and had a	E 0000		
K 0000 Bldg. 01	A Life Safety Code Licensure Survey w	Recertification and State vas conducted by the Indiana lth in accordance with 42 CFR 5/2023	K 0000	Please review for paper compliance.	
LABORATOR	Rehabilitation Cent with Requirements	Code survey, Autumn Ridge re was found not in compliance for Participation in	IGNATURF:	TITLE	(X6) DATE

(X6) DATE

Elizabeth Patton **Executive Director** 07/01/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155162		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 06/15/2023	
	PROVIDER OR SUPPLIER		600 W	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992	
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self-closing, but there was a chain attatached to the wall and the door not allowing the door to close. Based on interview at the time of observation, the MD agreed the door was held open with a device that would not release with the fire alarm. The MD disconnected the chain from the door which allowed the door to close. This finding was reviewed with the Administrator and MD at the exit conference. 3.1-19(b) The chain attached to the wall was removed. Staff educated on not holding door open with objects. 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; The Maintenance Supervisor or designee will complete an in-house audit of all doors to ensure further compliance. 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; and		1				-		
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ensure that the deficient practice does not recur; The Maintenance Supervisor or designee will complete an in-house audit of all doors to ensure further compliance. 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; and						I =		
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ensure further compliance. 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;and								
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will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and						ensure further compliance.		
will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and								
deficient practice will not recur, i.e., what quality assurance program will be put into place;and						How the corrective action(s)		
recur, i.e., what quality assurance program will be put into place;and						will be monitored to ensure t	:he	
assurance program will be put into place;and						deficient practice will not		
into place;and						recur, i.e., what quality		
						assurance program will be p	ut	
						into place;and		
							;	

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	OF CORRECTION	IDENTIFICATION NUMBER 155162	A. BUILDING B. WING	01	COMPLETED 06/15/2023
	ROVIDER 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)	DATE
K 0300	NEDA 101			corrective action will be monitorial via facility QAPI program, with meetings being held monthly, is overseen by the Executive Director. Maintenance Supervisor or designee will document on the Facility Doors K223 QAPI tool weekly x 4 weeks, monthly x 3 months, and quarterly there at until compliance is achieved. If Threshold of 90% is not met action plan will be developed the ensure compliance. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Platof Correction, if it is determined that the correction will not be completed by the date previously submitted, T Division needs to be contact as soon as possible. The fact will need to submit an amended plan of correction with the updated plan of correction date. 7/7/23 Please review for paper compliance.	and e on
SS=F Bldg. 01	Section 18.3 and 7 requirements that	KS section any LSC 19.3 Protection are not addressed by the ut are deficient. This			

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i ´					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	<u>01</u>	COMPLETED	
		155162	B. W	ING		06/15/2023	
	PROVIDER OR SUPPLIER		•	600 WA	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE		
AUTUMN	RIDGE KEHABILI	TATION CENTRE		WADAS	SH, 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	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	_	with the applicable Life					
	1	FPA standard citation,					
	should be included on Form CMS-2567. Based on observation and interview; the facility		I _V 0	300	What corrective action(s) will	07/07/2022	2
		battery operated smoke alarms	KU	300	What corrective action(s) will be accomplished for those	07/07/2023	3
		rere maintained. NFPA 101 in			residents found to have been	_	
	4.6.12.3 states existing life safety features obvious				affected by the deficient	"	
	to the public, if not required by the Code, shall be				practice;		
	maintained. NFPA 72, National Fire Alarm and				The battery-operated smoke		
	Signaling Code, 2010 Edition, Section 29.10 states				alarms have been replaced.		
	fire-warning equipment shall be maintained and				How other residents having	the	
	tested in accordance with the manufacturer's				potential to be affected by the		
	published instructions and per the requirements				same deficient practice will I		
	of Chapter 14. Section 14.2.1.1.1 Inspection,				identified and what corrective		
	testing, and maintenance programs shall satisfy				action(s) will be taken;		
	1 -	this Code and conform to the			All residents had the potential	to	
		turer's published instructions.			be affected by this deficient		
		tes unless otherwise			practice.		
	1	e manufacturer's published			What measures will be put in	nto	
	_	and multiple-station smoke			place and what systemic		
	_	aced when they fail to respond			changes will be made to		
		out shall not remain in service			ensure that the deficient		
		s from the date of manufacture.			practice does not recur;		
	·	ice could affect all residents,			The Maintenance Supervisor	or	
	staff, and visitors.				designee will complete an		
	Findings include:				in-house audit of all battery operated smoke alarms to en	curo	
	r manigs include:				further compliance.	Suic	
	Based on observation	on and interview; the facility			Maintenance Supervisor or		
		battery operated smoke alarms			designee will complete		
		were manufactured within the			inspection/monitoring monthly	v as	
		d on observation of battery			part of the monthly battery		
		rms in resident rooms it was			powered detector testing curre	ently	
	_	facture date was more than 10			done via a Tel's task.	, l	
	years old. Based on						
	1 -	for (MD), he was unaware of					
		ate of the smoke alarms. MD			How the corrective action(s)		
	indicated he would	check every battery operated			will be monitored to ensure		
	smoke alarm in all 1				deficient practice will not		
	manufacture date and replace if necessary.				recur, i.e., what quality		

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	COMPLETED
		155162	B. WI	NG		06/15/2023
	PROVIDER OR SUPPLIER			600 WA	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	and MD at the exit of 3.1-19(c)	viewed with the Administrator conference.			assurance program will be p into place; and On going compliance with this corrective action will be monit via facility QAPI program, with meetings being held monthly, is overseen by the Executive Director. Maintenance Supervisor or designee will document on the K300 QAPI tool on weekly x 4 weeks, monthly x 3 months, a quarterly there after until compliance is achieved. If Threshold of 90% is not met action plan will be developed ensure compliance. By what date the systemic changes for each deficiency will be completed. After submitting an acceptable Pla of Correction, if it is determined that the correction will not be completed by the date previously submitted, T Division needs to be contact as soon as possible. The fact will need to submit an amended plan of correction with the updated plan of correction date. 7/7/22 Please review for paper compliance.	ored and and an an an an an
K 0355	NFPA 101					
SS=D	Portable Fire Extir					
Bldg. 01	Portable Fire Extin	•				
		guishers are selected, d, and maintained in				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	7	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED	
		155162	B. W	ING		06/15/2023	
	DROLUBER OF SUPER-			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	C			ASHINGTON AVE		
	N RIDGE REHABILI	TATION CENTRE			SH, IN 46992		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMP	LETION
TAG	1	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY	D.	ATE
		NFPA 10, Standard for					
	Portable Fire Extir						
	18.3.5.12, 19.3.5.		17.0	255	NAME OF THE OWNER OWNE		7/2022
	Based on observation and interview, the facility failed to inspect 1 of 1 portable fire extinguishers		K 0	333	What corrective action(s) will be accomplished for those	1 0//0	7/2023
	_	onth. NFPA 10, Standard for			be accomplished for those		
	_				residents found to have been	'	
	Portable Fire Extinguishers, Section 7.2.1.2 states fire extinguishers shall be inspected either				affected by the deficient practice;		
	manually or by means of an electronic device /				The fire extinguisher located of	,n	
	system at a minimum of 30-day intervals. Section				the patio was inspected	"'	
	7.2.2 states periodic inspection or electronic				immediately and was found to	be	
	monitoring of fire extinguishers shall include a				in proper working condition.		
	check of at least the following items:				How other residents having	the	
	(1) Location in designated place				potential to be affected by th		
	(2) No obstruction to access or visibility				same deficient practice will		
	1 1	reading or indicator in the			identified and what corrective		
	operable range or p	_			action(s) will be taken;		
	(4) Fullness determ	ined by weighing or hefting for			All residents had the potential	to	
	self expelling-type	extinguishers,			be affected by this deficient		
	cartridge-operated	extinguishers, and pump tanks			practice.		
	(5) Condition of tire	es, wheels, carriage, hose, and			What measures will be put in	nto	
	nozzle for wheeled	extinguishers			place and what systemic		
		nrechargeable extinguishers			changes will be made to		
	using push to-test p				ensure that the deficient		
		es personnel making manual			practice does not recur;		
	•	ep records of all fire			The Maintenance Supervisor	or	
		cted, including those found to			designee will complete an		
	•	ction. Section 7.2.4.3 requires			in-house audit of all fire		
		hly manual inspections are			extinguishers to ensure furthe	r	
		the manual inspection was			compliance.		
	^	nitials of the person			The Maintenance Supervisor	or	
		pection shall be recorded.			designee will complete	.	
	_	nires where manual inspections			inspection/monitoring at mont	nly	
		rds for manual inspections			as part of the monthly fire	41.	
	_	ng or label attached to the fire			extinguisher inspection currer	uy	
		inspection checklist			done via a Tels task.		
		or by an electronic method.			How the competition action (-)		
	_	uires records shall be kept to least the last 12 monthly			How the corrective action(s) will be monitored to ensure	.h.	
		en performed. This deficient				.rre	
	I inspections have be	en performed. This deficient	ı		deficient practice will not		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPLI	ETED
		155162	B. W	ING		06/15/	2023
				CTREET	ADDRESS SITE STATE SID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
A I I T I IN 4N	L DIDOE DELLADILL	TATION OFNITSE			ASHINGTON AVE		
AUTUMN	I RIDGE REHABILI	TATION CENTRE		WABASH, IN 46992			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	_{TC}	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	' ⁻	DATE
	practice could affec	et staff and residents in the area			recur, i.e., what quality		
	of the patio.				assurance program will be p	ut	
	•				into place;and		
	Findings include:				On going compliance with this		
	8				corrective action will be monitor		
	Based on observation	on during a tour of the facility			via facility QAPI program, with		
		ce Director (MD) on 06/15/23			meetings being held monthly,		
		onthly inspection tag on the fire			is overseen by the Executive		
	extinguisher located on the patio lacked				Director.		
	documentation of a monthly inspection from				Maintenance Supervisor or		
	September 2022 through May 2023. Based on				designee will document on the	;	
	interview at the time of observation, the MD				Fire extinguishers K355 QAPI		
	confirmed the fire extinguisher located on the				on weekly x 4 weeks, monthly		
	patio was missing the September 2022 - May 2023				months, and quarterly there af		
	monthly inspection.				until compliance is achieved.		
					If Threshold of 90% is not met	an	
	This finding was re	viewed with the Administrator			action plan will be developed t		
	and MD at the exit				ensure compliance.		
					By what date the systemic		
	3.1-19(b)				changes for each deficiency		
					will be completed. After		
					submitting an acceptable Pla	ın	
					of Correction, if it is		
					determined that the correction	on	
					will not be completed by the		
					date previously submitted, T	he	
					Division needs to be contact	ed	
					as soon as possible. The fac	ility	
					will need to submit an		
					amended plan of correction		
					with the updated plan of		
					correction date.		
					7/7/23		
					Please review for paper		
					compliance.		
K 0511	NFPA 101						
SS=E	Utilities - Gas and	Electric					
Bldg. 01	Utilities - Gas and	Electric					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>01</u> COMPLETED				
		155162	B. W	ING		06/15/	2023
NAME OF I	DDOMDED OF GUIDN 151			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIEI			600 WA	ASHINGTON AVE		
AUTUMN	N RIDGE REHABILI	TATION CENTRE			SH, IN 46992		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCT		DATE
		gas or related gas piping PA 54, National Fuel Gas					
	Code, electrical wiring and equipment complies with NFPA 70, National Electric						
		stallations can continue in					
	service provided no hazard to life.						
	18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2						
		on and interview, the facility	K 0	511	What corrective action(s) wi	II	07/07/2023
		f 1 electrical junction boxes in			be accomplished for those		
	the attic above resident room 319 was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed				residents found to have bee	n	
					affected by the deficient		
	Terminals, Receptacles shall be enclosed so that				practice;		
	live wiring terminals are not exposed to contact.				The cover was replaced on th	ie	
	This deficient practice could affect 10 residents in				electrical junction box.		
	the area of room 31	9.			How other residents having		
					potential to be affected by the		
	Findings include:				same deficient practice will		
	D 1 1	1			identified and what corrective	/e	
		on during a tour of the facility			action(s) will be taken;	14-	
		ce Director (MD) on 06/15/23			All residents had the potential	το	
		e attic above room 319 there was on box with exposed wires			be affected by this deficient		
	1	no cover. Based on interview			practice. What measures will be put in	nto	
		vation, the MD acknowledged			place and what systemic	110	
		condition and confirmed that			changes will be made to		
	exposed wiring was				ensure that the deficient		
	1				practice does not recur;		
	This finding was re	viewed with the Administrator			The Maintenance Supervisor	or	
	and MD at the exit				designee will complete an		
					in-house audit of all electrical		
	3.1-19(b)				junction boxes to ensure furth	er	
					compliance.		
					How the corrective action(s)		
					will be monitored to ensure	the	
					deficient practice will not		
					recur, i.e., what quality		
					assurance program will be p	out	
					into place;and		
					On going compliance with this	3	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155162	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/15/2023
	PROVIDER OR SUPPLIE	R ITATION CENTRE	600 W	ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE SH, IN 46992	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) D BE COMPLETION DATE
				corrective action will be movia facility QAPI program, we meetings being held month is overseen by the Executive Director. Maintenance Supervisor of designee will document on Electrical boxes K511 QAF on weekly x 4 weeks, month months, and quarterly then until compliance is achieved if Threshold of 90% is not action plan will be developensure compliance. By what date the systemic changes for each deficier will be completed. After submitting an acceptable of Correction, if it is determined that the correwill not be completed by date previously submitted Division needs to be contas soon as possible. The will need to submit an amended plan of correction date. 7/7/23 Please review for paper compliance.	with nly, and ve or the PI tool thly x 3 e after ed. met an ed to c ncy Plan ection the d, The tacted facility
K 0920 SS=E Bldg. 01	Extens Electrical Equipm Extension Cords Power strips in a used for component	ent - Power Cords and ent - Power Cords and patient care vicinity are only ents of movable ed electrical equipment			

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED		
		155162	B. WING		06/15/2023		
NAME OF I	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD			
			600 WASHINGTON AVE				
AUTUM	N RIDGE REHABILI	TATION CENTRE	WABAS	SH, IN 46992			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)		
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
IAG			IAG		DATE		
	` ,	les that have been					
	1	alified personnel and meet					
		10.2.3.6. Power strips in					
	1	icinity may not be used for					
	, -	, personal electronics),					
		m care resident rooms that					
	do not use PCRE	E. Power strips for PCREE					
	meet UL 1363A o	r UL 60601-1. Power strips					
	for non-PCREE in	the patient care rooms					
	(outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed						
		re. Extension cords used					
	-	moved immediately upon					
		purpose for which it was					
		ts the conditions of 10.2.4.					
		9), 10.2.4 (NFPA 99), 400-8					
	1 '	(D) (NFPA 70), TIA 12-5					
		ation and interview, the facility	K 0920	What corrective action(s) wil	I 07/07/2023		
		f 1 power strip was not used as		be accomplished for those			
		d wiring to provide power		residents found to have been	1		
	equipment with a h			affected by the deficient			
	NFPA-70/2011, 40	0.8 state unless specifically		practice;			
	permitted in 400.7	flexible cords and cables shall		The refrigerator was plugged i	nto		
	not be used for (1)	as a substitute for fixed wiring.		the wall and the power strip wa	as		
	This deficient pract	rice could affect up to 2		removed immediately. All lamp	os		
	residents in residen	t room 326.		with built in plug ins were remo	•		
				immediately from rooms.			
	Findings include:			How other residents having t	the		
	<i>g</i>			potential to be affected by th			
	Based on observation	on during a tour of the facility		same deficient practice will be			
		ice Director (MD) on 06/15/23		identified and what correctiv			
		gerator (high power draw					
	_			action(s) will be taken;	to		
		agged into and supplied power		All residents had the potential	lO		
		resident room 326. Based on		be affected by this deficient			
		ne of observation, the		practice.			
	Maintenance Direct	tor acknowledged a power strip		What measures will be put in	ito		

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was supplying power to high power draw

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place and what systemic

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155162	B. W	ING		06/15/	/2023
		<u> </u>		CTDEET /	ADDRESS CITY STATE ZIR COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD ASHINGTON AVE		
A 1 1 T 1 1 A A		TATION CENTRE					
AU I UIVIN	I RIDGE REHABILI	TATION CENTRE		WABAS	SH, IN 46992		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		wer strip was removed by the			changes will be made to		
	MD at the time of d	liscovery.			ensure that the deficient		
					practice does not recur;		
		viewed with the Administrator			The Maintenance Supervisor	or	
	and MD at the exit	conference.			designee will complete an		
					in-house audit of all rooms to		
	3.1-19(b)				ensure further compliance.		
		ration and interview, the			How the corrective action(s)		
	-	sure 11 resident rooms did not			will be monitored to ensure t	:he	
	use flexible cords as a substitute for fixed wiring.				deficient practice will not		
	LSC 9.1.2 requires electrical wiring and equipment				recur, i.e., what quality		
	shall be in accordance with NFPA 70, National				assurance program will be p	ut	
		FPA 70, 2011 Edition, Article			into place;and		
	-	unless specifically permitted,			On going compliance with this		
		ables shall not be used as a			corrective action will be monitor		
		wiring of a structure. This			via facility QAPI program, with		
	-	ffects up to 15 residents and			meetings being held monthly,	and	
	staff.				is overseen by the Executive		
					Director.		
	Findings include:				Maintenance Supervisor or		
		0.6/1.5/00 14 4			designee will document on the	9	
		on on 06/15/23 with the			refrigerators and lamps K920		
		Maintenance Director (MD)			QAPI tool on weekly x 4 week		
	_	facility between the hours of			monthly x 3 months, and quar	terly	
	discovered:	p.m., the following was			there after until compliance is		
		ident room #212 had a mayyanad			achieved.	· on	
	_	ident room #312 had a powered			If Threshold of 90% is not met		
		t made them an extension			action plan will be developed t	iO	
	cord.	ident room #313 had a powered			ensure compliance.		
		t made them an extension			By what date the systemic		
	cord.	i made them an extension			changes for each deficiency		
		ident room #314 had a powered			will be completed. After submitting an acceptable Pla	n n	
		t made them an extension				31 <i>1</i>	
	cord.	i made them an extension			of Correction, if it is determined that the correction	\n	
		ident room #315 had a powered				711	
	_	t made them an extension			will not be completed by the	'ho	
		i made mem an extension			date previously submitted, T		
	cord.	ident room #216 had a mayyanad			Division needs to be contact		
	c) two lamps in resi	ident room #316 had a powered	1		as soon as possible. The fac	IIITV	I

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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 <u>01</u>		COMPLETED			
		155162	B. WING			06/15/2023		
NAME OF PROVIDER OR SUPPLIER AUTUMN RIDGE REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP COD 600 WASHINGTON AVE WABASH, IN 46992				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)	
PREFIX	· ·		F			TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	plug in the base that made them an extension cord. f) two lamps in resident room #317 had a powered plug in the base that made them an extension cord. g) two lamps in resident room #318 had a powered plug in the base that made them an extension cord. g) two lamps in resident room #319 had a powered plug in the base that made them an extension cord. h) two lamps in resident room #319 had a powered plug in the base that made them an extension cord. i) two lamps in resident room #320 had a powered plug in the base that made them an extension cord. j) one lamp in resident room #325 had a powered plug in the base that made it an extension cord. k) one lamp in resident room #344 had a powered plug in the base that made it an extension cord. Based on interview at the time of each observation, the Administrator and MD acknowledged each instance of extension cord usage and immediately started removing them from each of the resident rooms. This finding was reviewed with the Administrator and MD at the exit conference.				will need to submit an amended plan of correction with the updated plan of correction date. 7/7/23 Please review for paper compliance.			
3.1-19(b)			1					

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