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	03/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Ridge Rehabilitation Centre	600 Washington Ave Wabash, IN 46992

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observation and interview, the facility failed to ensure required State Agency and Ombudsman contact information was prominently displayed in a location and manner accessible to residents, specifically those utilizing wheelchairs. This deficient practice affected 3 of 3 residents reviewed for resident rights and had the potential to affect 21 residents residing on the 3rd floor of the facility. (Residents 5, 7, and 10)Findings include:During a Resident Council group interview, on 3/25/26 at 2:00 p.m., Residents 5, 7, and 10 each indicated they did not know where to find information for the local Ombudsman or where to find information about how to contact the State Agency with concerns. Resident 5 indicated he could ask the Activities Director (AD) for the information. The residents who lived on the third floor were prohibited from accessing the first floor without staff supervision. During an observation of the third floor, on 3/26/26 at 2:59 p.m., (the floor where Residents 5, 7, and 10 resided), there were no visible postings of State Agency or Ombudsman information. During an observation of the first floor on 3/26/26 at 3:34 p.m., the required State Agency information was posted on the wall next to the elevators. The posting did not include the Ombudsman's contact information. During an interview with the Director of Nursing (DON), on 3/31/26 at 10:53 a.m., she indicated residents residing on the third floor were not given the code to the elevator because there were other residents on the third floor who were elopement risks. All residents must be accompanied by a staff member when going downstairs.During an interview and observation with the AD on 3/31/26 at 11:18 a.m., the required State Agency informational poster was measured at four feet and ten inches, or 58 inches, from the ground. The AD indicated it would be difficult for a person sitting in a wheelchair to see the information at that height. A current facility policy, titled Resident Rights, provided by the Administrator on 3/31/26 at 10:12 a.m., indicated the following: .(The) facility must ensure that information is provided to each resident in a form and manner the resident can access and understand.Each facility must post the names, addresses and telephone numbers of all pertinent State client advocacy groups, including the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, the area agency on aging, the local mental health center and the Medicaid fraud control unit.410 IAC (Indiana Administrative Code) 16.23.1-4(j)(3)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview, and record review, the facility failed to protect residents' rights to choose to move within the facility and to spend time outdoors as able for 3 of 3 residents of 21 residents residing on the third floor reviewed for residents' rights. (Residents 5, 7, and 10)Findings include:During a Resident Council group interview, on 3/25/26 at 2:00 p.m., Residents 5, 7, and 10 each indicated the facility placed significant restrictions on their mobility and autonomy. The residents who lived on the third floor were prohibited from accessing the first floor or the outdoor patio without staff supervision. Key barriers included an elevator that required a keypad code, which had not been shared with the residents, and a locked exterior door leading to the patio. These restrictions prevented residents from visiting common areas such as the first-floor aquarium or the outdoor seating area at will. Resident 7 indicated she was prevented from going to the lobby to collect cups for coffee the previous evening. Residents 5, 7, and 10 each expressed a desire for independent access to both the facility's amenities and the outdoors. Resident 5 indicated they just wanted to go outside for some fresh air or to enjoy the sunshine. Resident 5 indicated the facility felt like a prison and both Residents 7 and 10 indicated they felt the same way. Resident 7's clinical record was reviewed on 3/27/26 at 1:44 p.m. Diagnoses included anxiety, depression, and vitamin D deficiency. An annual Minimum Data Set (MDS) assessment, dated 1/27/26, indicated Resident 7 was cognitively intact, had moderate depression and did not exhibit hallucinations, delusions, or behaviors. It was very important for Resident 7 to go outside for fresh air when weather permitted. A current care plan for activities, revised on 2/22/26, indicated Resident 7 enjoyed shopping, watching television, playing games, entertainment, and socializing with others. She was care-planned to participate in two to three activities per week, was to receive assistance to go to activities as needed and was to receive verbal reminders about activities of interest. Resident 10's clinical record was reviewed on 3/27/26 at 2:22 p.m. Diagnoses included anxiety, Vitamin D deficiency, and psoriatic arthritis. A comprehensive MDS assessment, dated 8/18/25, indicated Resident 10 was cognitively intact, exhibited no hallucinations, delusions, or behaviors, and was able to transfer independently in her wheelchair. It was very important for Resident 10 to go outside for fresh air when weather permitted. A current care plan for activities, revised on 2/2/26, indicated Resident 10 enjoyed reading the newspaper, reading the Bible and spending time with family. She enjoyed going outside when the weather was nice. She was care-planned to participate in activities of her choice and receive reminders about activities. Resident 5's clinical record was reviewed on 3/27/26 at 2:29 p.m. Diagnoses included type 2 diabetes, insomnia, heart failure, chronic pain, and Parkinson's disease. An annual MDS assessment, dated 3/17/26, indicated Resident 5 was cognitively intact, exhibited no hallucinations, delusions, or behaviors, and was able to transfer independently in his wheelchair. It was very important for Resident 5 to go outside for fresh air when the weather permitted. A current care plan for activities, revised 3/18/26, indicated Resident 5 enjoyed playing bingo and other card and board games. He enjoyed going outside when the weather was good. He was able to make his own choices for activities. He was care-planned to receive assistance to activities as needed as well as reminders about activities. During an interview on 3/27/26 at 3:38 p.m., the Activities Director (AD) indicated outside activities were provided when the weather permitted. If a resident wanted to go outside and a staff member was available to accompany them, then residents could go outside. The reason residents must be supervised was because corporate wanted it that way. There were residents in the facility who would be fine to go outside unsupervised. During an interview with the Director of Nursing (DON), on 3/31/26 at 10:53 a.m., she indicated residents residing on the third floor were not given the code to the elevator because there were other residents on the third floor who were elopement risks. Most activities took place on the first floor. All residents must be accompanied by a staff member when going downstairs. The outside-access door to the patio was locked because (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of a previous resident elopement. She did not remember when that incident took place, but it had been several years. The aides did not have time to take the residents downstairs and/or outside. The aides were supposed to contact the AD, who would then accompany the residents downstairs and/or outside. The elevator was intended to be a barrier to get to the first floor. During an interview with the Administrator, on 3/31/26 at 1:15 p.m., he indicated there was no facility policy for keeping the third floor secured. The elevator required a code, and residents were not allowed to have the code. The residents could move through the facility freely with supervision. Supervision was always provided for the residents. Technically, if a resident lived on one end of the third floor and propelled themselves to the other end of the unit, then they had freedom of movement. Residents who wanted to go outside had to be supervised. If a resident asked to go outside, they should be allowed to go, provided there was supervision available to accompany them. It was a less-than-ideal set-up, but at least it was safe. Supervision could be provided by the receptionist or other staff in the lobby area.The third floor March 2026 activities calendar, provided by the AD on 3/27/26 at 3:38 p.m., lacked scheduled outdoor activities for the month.A current facility policy, titled Resident Rights, provided by the Administrator on 3/31/26 at 10:12 a.m., indicated the following: .(The) facility must ensure that the resident can exercise his or her rights without interference coercion, discrimination, or reprisal from the facility.On 3/30/26 at 12:09 p.m., the Administrator indicated the facility did not have a policy for residents going outside. 410 IAC (Indiana Administrative Code) 16.2 - 3.1-3(a)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to ensure residents received bathing assistance according to their assessed needs and preferences for 1 of 1 resident reviewed for activities of daily living (ADLs). (Resident 7) Findings include:On 3/24/26 at 12:45 p.m., during the lunch meal, Resident 7 was observed seated at a dining table. Resident 7's hair was greasy and disheveled.During the Resident Council group interview, on 3/25/26 at 2:04 p.m., Resident 7 indicated she had not received a shower for over a week. Her hair was still greasy and stringy, and she was wearing the same clothes from the day before. Saturdays and Tuesdays were her scheduled shower days, but she did not receive a shower on either scheduled day. Resident 7 was willing to take a shower at any time of day and although Tuesdays and Saturdays were her assigned days, she was willing to change days if it would help staff. She had never refused a shower.Resident 7's clinical record was reviewed on 3/27/26 at 1:44 p.m. Diagnoses included anxiety, depression, and Vitamin D deficiency.An annual Minimum Data Set (MDS) assessment, dated 1/27/26, indicated Resident 7 was cognitively intact. It was very important for Resident 7 to choose between a shower, bed bath, or sponge bath. She was frequently incontinent of both bladder and bowel. She required partial to moderate assistance for bathing/showering.Facility shower sheets for the month of March 2026 through the survey dates, provided by the DON on 3/25/26 at 3:46 p.m., indicated the following:On Saturday, 3/7/26, the shower sheet indicated Resident 7 received a shower.On Tuesday, 3/10/26, the shower sheet indicated Resident 7 received a complete bed bath and her hair was washed.On Tuesday, 3/17/26, the shower sheet was blank except for the resident's name and date.On Saturday, 3/21/26, the shower sheet indicated the resident refused a shower.On Tuesday, 3/24/26, the shower sheet was blank except for the resident's name and date.A review of Resident 7's March 2026 Point of Care History for bathing indicated the following:3/1/26 at 12:23 a.m. - Partial Bed Bath (PBB) 8:51 a.m. - Shower 8:03 a.m. - PBB3/2/26 at 12:00 a.m. - PBB 10:48 a.m. - PBB 8:00 a.m. - PBB 11:51 a.m. - PBB3/3/26 at 10:58 a.m. - PBB 3:49 p.m. - PBB3/4/26 at 12:42 a.m. - PBB 9:50 a.m. - activity did not occur 5:29 p.m. - PBB 11:33 p.m. - PBB3/5/26 at 7:11 a.m. - PBB 8:24 p.m. - PBB 11:34 p.m. - PBB3/6/26 at 10:14 a.m. - activity did not occur 7:57 p.m. - PBB3/7/26 at 12:26 a.m. - PBB 1:11 p.m. - Shower 7:42 p.m. - PBB3/8/26 at 12:24 a.m. - PBB 12:43 p.m. - activity did not occur 8:44 p.m. - PBB3/9/26 at 12:49 a.m. - PBB 8:58 a.m. - PBB 5:11 p.m. - PBB3/10/26 at 12:00 a.m. - PBB 10:29 a.m. - PBB 9:16 p.m. - PBB 11:12 p.m. - PBB3/11/26 at 4:42 p.m. - PBB3/12/26 at 2:42 a.m. - PBB 11:19 a.m. - PBB 7:38 p.m. - PBB3/13/26 at 1:54 a.m. - activity did not occur 3:55 p.m. - PBB 11:29 p.m. - PBB3/14/26 at 10:33 a.m. - PBB 7:41 p.m. - PBB 11:29 p.m. - PBB3/15/26 at 9:41 a.m. - PBB 3:14 p.m. - PBB 11:46 p.m. - PBB3/16/26 at 11:06 a.m. - PBB 8:55 p.m. - PBB3/17/26 at 3:58 a.m. - activity did not occur 10:06 a.m. - PBB 4:10 p.m. - PBB3/18/26 at 12:38 a.m. - PBB 9:00 a.m. - activity did not occur 3:18 p.m. - PBB3/19/26 at 8:11 a.m. - activity did not occur 7:06 p.m. - PBB 11:22 p.m. - PBB3/20/26 at 1:59 p.m. - activity did not occur 9:23 p.m. - PBB3/21/26 at 12:13 a.m. - PBB 1:36 p.m. - activity did not occur 3:31 p.m. - PBB3/22/26 at 12:36 a.m. - PBB 1:16 p.m. - activity did not occur 3:49 p.m. - PBB3/23/26 at 2:42 a.m. - activity did not occur 9:50 a.m. - PBB 7:00 p.m. - PBB3/24/26 at 12:12 a.m. - PBB 1:31 p.m. - PBB 7:46 p.m. - PBB 11:54 p.m. - PBB3/25/26 at 10:48 a.m. - activity did not occur 6:58 p.m. - PBBDuring an interview with CNA 10 on 3/25/26 at 3:37 p.m., she indicated the sheets at the front of the shower sheet binder were filled out with the residents' names and dates. CNAs would pull the blank sheets each day and provide showers for the residents on their assigned shower days. A blank shower sheet could mean different things. The resident could have refused, or the CNA possibly forgot to fill out the sheet. A shower sheet without a signature would indicate the shower was missed or ignored.During an interview with the Director of Nursing (DON), on 3/25/26 at 3:46 p.m., she indicated a blank shower sheet meant no shower had occurred. If there was only a signature, she would ask the residents if they got their shower. During an interview, on 3/26/26 at 9:51 a.m., CNA 7 indicated she provided showers whenever it worked best for the resident, and that (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	some residents preferred to wait until the afternoon. She added that she tried to get all showers done before lunch and on her assigned weekends, and staff did a lot of extra showers. If a shower sheet contained only a signature and nothing more, it might be staff forgot to fill out the details. She was not sure if staff documented peri-care as a partial bed bath. During an interview on 3/31/26 at 12:55 p.m., CNA 8 indicated a partial bed bath consisted of taking the residents to the bathroom, allowing them to use the restroom, and then bringing in a wash basin with two cloths-one with soapy water and one with rinse water. She indicated she began with the face, armpits, then front and back of the peri-area. She preferred to allow the residents to wash their own hands, face, and armpits when possible. Any time she performed peri-care, she documented that as a partial bed bath.During an interview with CNA 9 on 3/31/26 at 1:00 p.m., she indicated a partial bed bath included washing the resident's peri-area and legs, and sometimes their backs. The only option in the electronic health record was to mark peri-care as a partial bed bath. A partial bed bath could mean just peri-care or an actual partial bed bath. If a resident had four partial bed baths documented on any given day, there was no way to know if it was just peri-care or an actual partial bed bath.On 3/30/26 at 2:46 p.m., the Administrator indicated there was no facility policy regarding showering/bathing.A current facility policy, titled Resident Rights, provided by the Administrator on 3/30/26 at 2:46 p.m., indicated the following: .All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well-being, and proper delivery of care. 410 IAC (Indiana Administrative Code) 16.2 - 3.1-38(a)(3)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation and interview, the facility failed to ensure a resident with complaints of mouth pain was assessed and provided interventions to provide comfort for 1 of 3 residents reviewed for pain. (Resident 22). Findings include:A breakfast observation, in the 3rd floor dining room on 3/25/26, indicated the following:At 8:29 a.m., Resident 22 openly communicated out loud she had a bad toothache. Resident 22 was guarding her right lower jaw and stated, it really hurts. RN 3 walked near Resident 22. Resident 22 looked toward RN 3 and indicated she had a bad toothache. RN 3 continued walking past Resident 22 without acknowledging Resident 22's toothache complaints. RN 3 sat down at a table directly behind Resident 22 to assist another resident with eating. Resident 22 continued stating, it hurts, it hurts a lot, while indicating she had a dental appointment that morning. Resident 22 declined eating breakfast.At 8:39 a.m., Resident 22 was grimacing and stating her tooth hurt. RN 3 continued to assist another resident with meal service at a table directly behind Resident 22. Two CNA were walking in and out of the dining room delivering hall trays to residents. When the two CNA's entered the dining room, they were approximately ten feet away from Resident 22.At 8:44 a.m.- CNA 7 asked RN 3 when Resident 22's dental appointment was. RN 3 shrugged her shoulders and stated, I am not looking while RN 3 continued to assist another resident. Resident 22 continued to indicate she had a dental appointment and needed to go there now.At 8:50 a.m., Resident 22 was crying out in pain, stating it hurts so bad, please. RN 3 asked CNA 7 to get the DON to assist Resident 22. Resident 22's crying out intensified as she indicated she needed to see the dentist right away as it hurt badly.At 8:51 a.m., the DON entered the 3rd floor dining room and walked over to Resident 22. The DON notified Resident 22 that her dental appointment was not today, and staff would get her some Orajel (oral numbing anesthetic).At 8:52 a.m., CNA 7 took over assisting the other resident for RN 3. RN 3 walked down the hallway toward the nurse's station while the DON propelled Resident 22 behind RN 3. As Resident 22 was propelled toward the nurses' station, Resident 22 stated she was in horrible pain.8:53 a.m., RN 3 administered Orajel to Resident 22 on a disposable mouth sponge. Resident 22 applied the sponge to her gums. The DON indicated Resident 22 was edentulous (no natural teeth) and RN 3 would check if Resident 22 could have any pain medication. The DON propelled Resident 22 down the hallway to her room while RN 3 checked to see if Resident 22 could have any pain medication.At 8:57 a.m., RN 3 administered some acetaminophen (Tylenol, for pain or fever) to Resident 22.During an interview, on 3/25/26 at 8:59 a.m., RN 3 indicated she was unaware she could leave the dining room to administer pain medication to Resident 22. She thought she had to remain in the dining room, in case of an emergency. RN 3 could not recall shrugging her shoulders and stating she would not look when Resident 22's dental appointment was.During an interview, on 3/25/26 at 10:22 a.m., Resident 22 indicated staff did not give her any pain medication that morning and she had to suffer with mouth pain. She was going to the dentist later today.Resident 22's clinical record was reviewed on 3/27/26 at 1:38 p.m. Diagnoses included Parkinson's disease, dementia, seizures, anxiety, chronic pain and pain disorder related to psychological factors.Current orders included acetaminophen 500 milligram (mg) every six hours, give with Tramadol (prescription pain reliever) 50 mg, Orajel (over the counter oral numbing gel) toothache-gum, one application on mucus membrane every six hours as needed and acetaminophen 650 mg every four hours as needed. A 3/11/26, quarterly, Minimum Data Set (MDS) assessment indicated Resident 22 was moderately cognitively impaired. She received scheduled and as needed pain medications, she was frequently in pain, and pain interfered with sleep and daily activities frequently. Resident 22's verbal description of pain was severe.A current care plan, dated 1/11/24 and reviewed on 3/27/26, indicated Resident 22 called out for staff at times when cold, wet, mouth pain, or needed assistance. Interventions included offer hot tea (3/27/26) and meet resident needs/wants (1/11/24).A current care plan, dated 2/13/18 and reviewed 3/31/26, indicated Resident 22 was at risk for pain related to decreased mobility, osteoarthritis in bilateral knees, muscle weakness, diabetes, COPD (chronic obstructive pulmonary (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disease), other abnormalities of gait and mobility, dementia, chronic pain, general discomfort. Interventions included administering pain medication as ordered (2/13/18), assist with positioning to comfort (2/13/18), document effectiveness of as needed medications (2/13/18), notify physician if pain is unrelieved and/or worsening (2/13/18), and offer nonpharmacological interventions such as quiet environment, rest, shower, back rub, or reposition (2/13/18).A behavior note, dated 3/26/26 at 6:23 a.m., indicated Resident 22 complained of discomfort to her mouth, and then changed her complaint to discomfort of her ear after staff administered medication for mouth pain. Orajel was administered per order, warm tea was accepted, and a movie was playing on the television.A progress note, dated 3/27/26 at 10:23 a.m., indicated Resident 22 was seen by the Nurse Practitioner (NP) for increased complaints of pain to her gums. A new order was received for gabapentin (prescription nerve pain reliever) 100 mg twice a day.A progress note, dated 3/27/26 at 11:37 a.m., indicated staff followed up with Resident 22 regarding her behavioral expression. Resident 22 has had some mouth pain which had switched to ear pain. No signs or symptoms of psycho-social distress were noted and she would be monitored.During an interview, on 3/30/36 at 2:47 p.m., LPN 4 indicated she usually tried to look right away to see if a resident experiencing pain can receive any medication. If they were unable to have medication, she would try to offer other ways to elevate the pain such as repositioning the resident. For Resident 22, they could offer Orajel or sometimes hot tea. Resident 22 did receive scheduled pain medications. Resident 22 did complain of pain a couple times a day. During an interview, on 3/30/26 at 2:59 p.m., LPN 5 indicated she would assess any resident complaining of mouth or jaw pain. If there are any abnormalities, she would notify the physician for orders. She would check to see if any pain medication was able to be administered. If it was too soon to administer pain medication, she would try a warm or cold compress to the area.During an interview, on 3/30/26 at 3:17 p.m., RN 3 indicated she should have acted quicker when Resident 22 was complaining of dental pain. She should have assessed her, but Resident 22 had been to the dentist previously and had received her scheduled pain medications that morning.During an interview, on 3/31/26 at 10:50 a.m., the DON indicated RN 3 should have assessed Resident 22 when she first started to complain of mouth pain. It is not uncommon for Resident 22 to complain of mouth pain. She had seen the dentist previously. Resident 22 did have some attention seeking behaviors, but pain isn't something you normally go to when attention seeking. Staff should address the pain complaint first, as pain is subjective.A current facility policy, dated 1/2003 and titled Pain Management Policy, provided by the Administrator, on 3/31/25 at 11:51 a.m., indicated the following: . Policy: It is the policy of American Senior Communities to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, including pain management. 3. Interviewable residents- pain medications will be prescribed and given upon based upon the intensity of the pain as follows using the verbal descriptive, numerical scale (1-10) or Wong-Baker FACES scale. 410 Indiana Administrative Code (IAC) 16.2-3.1-37(a)