

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155681	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/06/2025
NAME OF PROVIDER OR SUPPLIER Autumn Woods Health Campus		STREET ADDRESS, CITY, STATE, ZIP CODE 2911 Green Valley Rd New Albany, IN 47150	

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on interview and record review, the facility failed to ensure residents (Resident D and Resident E) plan of care accurately reflected documented behaviors for 2 of 4 residents reviewed for comprehensive care plans. Findings include: 1. The clinical record for Resident D was reviewed on 11/6/25 at 10:50 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, dementia and psychotic disorder with delusions. The progress note, dated 9/5/25 at 1:11 p.m., indicated the resident had been resistive to care, attempted to hit staff and grab at the staff's wrists while staff attempted to dress him. The progress note, dated 9/18/25 at 4:39 p.m., indicated the resident had been aggressive with staff. The resident punched a staff member in the face and the punched another staff member in the stomach. The progress note, dated 9/24/25 at 9:36 a.m., indicated the psychiatric nurse practitioner had given an order to increase the resident's REXULTI (medication used for agitation) due to increased agitation and physical aggression towards the staff. The progress note, dated 10/12/25 at 6:45 p.m., indicated the resident had thrown his drink on the nurse and another resident. The progress note, dated 10/17/25 at 10:15 p.m., indicated the resident threw some of his coffee at a staff member. The progress note, dated 10/23/25 at 1:58 p.m., indicated the resident became agitated and attempted to hit the hospice aide. The progress note, dated 11/2/25 at 8:42 p.m., indicated the resident had been very restless and combative with staff, even after all medications and as needed medications had been administered. The progress note, dated 11/4/24 at 10:59 a.m., indicated the resident had been up in his wheelchair, at the end of the hall, kicking at the door repeatedly to make it beep. The resident required staff redirection several times prior to moving away from the door smacking at the staff. Review of the resident's care plan lacked documentation of a comprehensive plan of care for the resident's behaviors. During an interview, on 11/6/25 at 1:45 p.m., the Legacy Lane Leader indicated specific behaviors should be care planned if it affects the resident's activities of daily living or other residents. Aggression towards residents and staff should be care planned. 2. The clinical record for Resident E was reviewed on 11/6/25 at 11:03 a.m. The resident's diagnoses included, but were not limited to, dementia with other behavioral disturbances and generalized anxiety. The care plan, dated 10/13/25, indicated the resident demonstrated physically aggressive and resistive behaviors toward staff during hands on care. The progress note, dated 10/12/25 at 5:15 p.m., indicated the Resident E had punched another resident in the forehead. The resident's were separated. Review of Resident E's plan of care lacked documentation for the behavior and risk for aggression towards residents. On 11/6/25 at 1:30 p.m., the Director of Health Services provided a current copy of the document titled Comprehensive Care Plan Guideline dated 5/22/2018. It included, but was not limited to, Purpose Statement. To ensure appropriateness of services and communication that will meet the resident's needs, severity/stability of conditions in accordance with state and federal guidelines. Procedure. Should new identified areas of concerns arise during the resident's stay, they should be addressed on the care plan. A comprehensive care plan will be developed. Problem areas should identify the relative concerns. Goals should be measurable and attainable. Interventions should be reflective of the individual's needs. Comprehensive care plans need to remain accurate and current. 3.1-35(a)3.1-35(b)(1)</p>		