

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365380	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER Autumnwood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 670 E Sr 18 Tiffin, OH 44883	

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)
<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990</p> <p>Based on family and staff interview, interview with the Long Term Care Ombudsman, interview with hospital staff, record review, and policy review, the facility failed to provide the required documentation when a resident was initially transferred to the hospital for evaluation and treatment and the resident was later discharged from the facility. The facility also failed to ensure there was necessary reasons to transfer the resident to the hospital. This affected one (Resident #76) of three residents reviewed for discharges. The facility census was 75.</p> <p>Findings include:</p> <p>Review of Resident #76's closed medical record revealed an admitted [DATE]. Medical diagnoses included Alzheimer's disease, spinal stenosis, congestive heart failure, and ischemic heart disease. Resident #76 was transferred to an acute, inpatient, geriatric psychiatric facility on [DATE] on a 72-hour involuntary hold placed by Certified Nurse Practitioner (CNP) #210. Resident #76 was previously hospitalized at the same facility from [DATE] to [DATE].</p> <p>Review of Resident #76's Minimum Data Set (MDS) 3.0 discharge return anticipated assessment, dated [DATE], revealed the resident was identified with a memory problem and required modified independence with cognitive skills for daily decision making. Resident #76 was not noted to have any hallucinations, delusions, and was noted to have physical behavioral symptoms directed towards others on one to three days during the seven-day lookback period.</p> <p>Review of Resident #76's care plan, revised on [DATE], revealed the resident was at risk for complications and side effects from psychotropic drug use. The care plan identified this resident as being followed by a behavioral health team for behavior and medication management. Resident #76 was noted to take routine psychotropic medications and was at risk for continued mood fluctuations, physical decline, and falls. Resident #76 had a history of hitting his call light for no reason, verbally and sexually abusive comments directed towards staff, and at times was inappropriate towards other residents.</p> <p>(continued on next page)</p>

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 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #76's interdisciplinary progress notes revealed a note dated [DATE] at 2:48 P.M. which stated Resident #76 was noted in the dining room in his wheelchair with two other residents and a staff member. The resident was noted to be talking in a loud tone with his arms in the air. Resident #76 was removed from the area and questioned what the situation was and stated he was upset. Resident #76 stated he had been attempting to get past another resident who would not move out of his way, and he swatted at her. The resident stated it upset him that the other resident moved chairs in the dining room and that he did nothing wrong. A follow-up note dated [DATE] at 3:02 P.M. revealed the behavioral health provider was updated. A subsequent note dated 5:25 P.M. revealed a new order had been received for Resident #76 to go to an acute, inpatient, geriatric psychiatric facility. The resident was informed of the transfer and was agreeable. The note indicated bed hold obtained but the resident stated he did not like the facility. Resident #76 was transported to the geriatric psychiatric facility by the facility. The facility attempted to phone the resident's emergency contact but there was no answer and a voicemail was left. Prior to [DATE], the resident's only recent aggression recorded in the progress notes included Resident #76 giving a mean look and throwing a newspaper at a staff member during an activity. A follow up note on [DATE] authored by Social Services Director #250 indicated she spoke with the resident regarding the conflict. No additional documentation of behaviors were recorded after the resident readmitted to the facility on [DATE].</p> <p>Review of an Application for Emergency Admission (commonly known as a pink slip) form, dated [DATE] at 3:48 P.M. revealed Resident #76 was noted as a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness and would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself. The statement of belief section at the bottom of the form stated Resident #76 demonstrated verbal and physical aggression towards staff and other residents at the facility at which he resides. The form was signed by CNP #210.</p> <p>Review of Resident #76's Behavioral Health Intake form for the acute, inpatient, geriatric psychiatric facility, dated [DATE], revealed the resident had verbally and physically assaulted a peer. The form indicated Resident #76 had been a direct admit to the facility, and his discharge plan included returning back to the facility if the patient declined voluntary admission. The form additionally noted Resident #76 had worsening aggression and had raised his voice at peers.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #76's inpatient hospital progress notes revealed a note dated [DATE] at 2:53 P.M. authored by a hospital social worker stating a call was placed to the facility social worker to discuss the patient's hospital discharge and his pink slip expiring. Hospital social worker informed the facility social worker the resident would need to return prior to his pink slip expiring, and questioned if the facility would be able to pick the resident up the following day. The facility social worker stated the facility was trying to avoid allowing Resident #76 to re-admit. A subsequent note dated [DATE] at 8:58 A.M. revealed the hospital social worker attempted to discuss alternate placement options with Resident #76. The resident refused to consider alternate placement options and stated he wanted to remain in [NAME]. The hospital social worker shared with Resident #76 that he may not be able to return to the facility long term and stated she wanted to help him have an alternate place to live. The resident continued to refuse to consider alternate placement. A hospital note dated [DATE] at 1:05 P.M. authored by a hospital nurse revealed Resident #76 was concerned about his wheelchair at the facility and stated he did not want to go back to the facility. There was no other documentation stating the resident did not return back to the facility. On [DATE], the hospital requested a discharge notice but the facility refused to provide one.</p> <p>Review of Resident #76's medical record revealed no evidence of a 30-day or emergency discharge notice being completed and provided to Resident #76 and/or his representative.</p> <p>A telephone interview on [DATE] at 8:52 A.M. with the facility Ombudsman revealed she had been contacted by the staff at the hospital where Resident #76 was at and was informed the facility would not accept Resident #76 for readmission upon the conclusion of his acute, inpatient stay. The Ombudsman indicated she had emailed and spoken to the facility Administrator who believed the resident's treatment at the hospital was incomplete, and the facility had only received the referral one day prior to the Ombudsman reaching out to the facility.</p> <p>An interview on [DATE] at 9:25 A.M. with the Administrator revealed Resident #76 was transported to the acute, inpatient, geriatric psychiatric facility on [DATE] following an incident of verbal aggression directed at an unnamed resident. The Administrator stated a resident had accidentally stepped on his foot in the dining room and Resident #76 attempted to strike the other resident, but did not make physical contact. The Administrator stated there had been ongoing verbal aggression by Resident #76 towards staff members, and he had a behavioral health team overseeing his care while a resident of the facility. The Administrator indicated Resident #76's transfer to the hospital was initially intended to be short term, and intended for Resident #76 to return back to the facility once stabilized. The Administrator stated that himself and the Director of Nursing (DON) had drove Resident #76 to the hospital on [DATE], at which time Resident #76 verbally stated he wished to be a bed hold.</p> <p>A telephone interview on [DATE] at 11:28 A.M. with Hospital Worker #115 revealed she was familiar with Resident #76's care and stated it was a clear instance of patient dumping. Hospital Worker #115 stated they have no long term care unit, and no long term beds, and would never have accepted a patient there for long-term care if they had no place to return to. Hospital Worker #115 believed the facility staff exaggerated Resident #76's behaviors, stating it was a stretch to say Resident #76 was aggressive, rather the resident shares his opinions and makes statements of his observations. Hospital Worker #115 stated the resident had consistently voiced that he wished to return to the facility. Hospital Worker #115 stated around the time the resident's pink slip expired (on or around [DATE]), the resident received a call at the facility from an unknown person at the facility stating that if the resident's belongings were not removed from the building, the belongings would be removed from the room.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview on [DATE] at 12:32 P.M. with Hospital Worker #140 revealed Resident #76 was transported by the facility to the acute, inpatient hospital for a psychiatric stay. The facility had reported Resident #76 displayed sexually inappropriate behaviors. Before the hospital accepted the patient, since Resident #76 was listed as his own responsible party, the hospital verified the resident would be allowed to return after his pink slip expired, to which the facility Administrator had agreed. Hospital Worker #140 stated they do not require facilities to sign anything, rather it was a verbal agreement. The day before Resident #76 was to discharge back to the facility, the facility stated they would not accept Resident #76 back for re-admission. Hospital Worker #140 explained if Resident #76 did not voluntary sign in to continue care at the acute hospital at the conclusion of the pink slip expiring, the resident would have no where to go. Hospital Worker #140 stated Resident #76 did agree to sign in after discussion with a provider, but stated to hospital staff he had felt coerced, but agreed to stay. Hospital Worker #140 stated she had been told by the facility there was a formal discharge letter provided to Resident #76 which stated he could not return to the facility, but that later proved to be untrue. Hospital Worker #140 stated Resident #76 remained a patient at the hospital and wanted to return to the facility.</p> <p>An interview on [DATE] at 1:07 P.M. with Social Services Director (SSD) #210 revealed the resident made occasional comments in nature, primarily to staff members. SSD #210 stated the comments were not really overtly sexual, but were annoying and rude. SSD #210 went on to describe Resident #76 as not always inappropriate, and described him as being kind, nice and fun.</p> <p>An telephone interview on [DATE] at 1:28 P.M. with a family member of Resident #76 revealed the family member as angry, stating the resident's discharge situation was not handled correctly. The family member indicated Resident #76 had no where to go and was homeless as the facility refused to allow the resident to return to the facility. The family member stated that on the date of the transfer to the hospital, [DATE], an unnamed female resident had wheeled her wheelchair onto his foot in the dining room and sat there. This caused pain to Resident #76's foot, and the resident instinctively reached forward to wheel her off of his foot. Resident #76's family member stated that the facility stated the resident was trying to hit another resident. The family member stated they were not informed of a time frame or estimated length of stay for the hospitalization, but when told Resident #76 had been pink slipped, the family member believed it to be only for a few days, as it had been the time before in [DATE]. Resident #76's family member stated they were confused, as the hospital staff reported to the family they were unsure why Resident #76 had to remain hospitalized and could not return to his home at the facility. The family member stated Resident #76 never received a discharge notice from the facility, nor did Resident #76.</p> <p>An interview on [DATE] at 1:48 P.M. with the Director of Nursing (DON) revealed the resident never struck or assaulted another resident prior to his hospital transport. The DON stated she was unaware why the pink slip indicated Resident #76 assaulted someone and stated that did not happen, nor had the DON ever seen a copy of the pink slip or the hospital intake form. The DON verified the statement on the pink slip and hospital intake form was incorrect, and rather Resident #76 had potentially shown physical aggression by waving his arms around and attempting to strike other residents.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on [DATE] at 2:05 P.M. with the Administrator and DON additionally verified Resident #76 did not physically assault another resident and the pink slip form was incorrect. The DON indicated Resident #76's behaviors should be documented in the interdisciplinary progress notes in the electronic medical record, and verified there was not recent documentation, prior to the hospital transfer on [DATE], of Resident #76 exhibiting verbal, sexual, or physical behaviors, outside of the resident throwing a newspaper during an activity. The DON and Administrator reported Resident #76 as having frequent verbal behaviors, but those were reflected in Resident #76's medical record. The Administrator confirmed there had never been a discharge notice provided to the resident or their representative. The Administrator confirmed the facility initially had Resident #76 as a bed hold, but the Administrator decided not to hold the bed with no additional conversation with the resident or the resident's representative.</p> <p>A telephone interview on [DATE] at 2:31 P.M. with CNP #210 revealed she oversaw Resident #76's behavior and psychiatric care at the facility. CNP #210 stated she does a lot of education with the facility, and treatment approaches include non-pharmacological interventions prior to medication use. CNP #210 verified the lack of behaviors documented in Resident #76's medical record at the facility. CNP #210 stated she was initially contacted on the afternoon of [DATE] and told that Resident #76 had been physically and verbally abusive towards another resident, which was why she documented verbally and physically assaulted a resident on the pink slip. CNP #210 stated she found out later that Resident #76 never struck another resident. She stated the initial report of the resident striking another resident made a difference in how she documented and what she based her treatment decisions on. CNP #210 stated other care team members involved with Resident #76's care had encouraged the facility to properly provide Resident #76 with a discharge notice, but to her knowledge the resident or their representative had yet to receive one. CNP #210 stated Resident #76 had voiced his desire to return to the facility.</p> <p>An interview on [DATE] at 3:32 P.M. with Registered Nurse (RN) #225 revealed she was familiar with Resident #76 and described him as ornery and sometimes verbally inappropriate. RN #224 did not believe Resident #76 was or had ever been a risk to himself or others, and stated she did not believe he was dangerous to himself or others.</p> <p>Review of the policy titled Permitting Residents to Return to Facility after hospitalization of Therapeutic Leave, dated [DATE], revealed not permitting residents to return following hospitalization or therapeutic leave constitutes a facility-initiated discharge and requires a facility to meet additional requirements. The policy stated a facility must not discharge a resident unless the discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs; the resident's health has improved sufficiently so that the resident no longer needs the services of the facility; the resident's clinical or behavioral status endangers the health of the individuals in the facility; The resident has failed to pay for his stay at the facility; or the facility ceases to operate.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00154903 and Complaint Number OH00154426.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990</p> <p>Based on family and staff interview, interview with hospital staff, record review, and policy review, the facility failed to provide the resident and the resident's representative of the appropriate written notice upon discharge. This affected one (Resident #76) of three residents reviewed for discharges. The facility census was 75.</p> <p>Findings include:</p> <p>Review of Resident #76's closed medical record revealed an admitted [DATE]. Medical diagnoses included Alzheimer's disease, spinal stenosis, congestive heart failure, and ischemic heart disease. Resident #76 was transferred to an acute, inpatient, geriatric psychiatric facility on 05/24/24 on a 72-hour involuntary hold placed by Certified Nurse Practitioner (CNP) #210.</p> <p>Review of Resident #76's Minimum Data Set (MDS) 3.0 discharge return anticipated assessment, dated 05/24/24, revealed the resident was identified with a memory problem and required modified independence with cognitive skills for daily decision making.</p> <p>Review of Resident #76's interdisciplinary progress notes revealed a note dated 05/24/24 at 2:48 P.M. which stated Resident #76 was noted in the dining room in his wheelchair with two other residents and a staff member. The resident was noted to be talking in a loud tone with his arms in the air. Resident #76 stated he had been attempting to get past another resident who would not move out of his way, and he swatted at her. A follow-up note dated 05/24/24 at 3:02 P.M. revealed the behavioral health provider was updated. A subsequent noted timed 5:25 P.M. revealed a new order had been received for Resident #76 to go to an acute, inpatient, geriatric psychiatric facility. Resident #76 was transported to the geriatric psychiatric facility by the facility.</p> <p>Review of Resident #76's Behavioral Health Intake form for the acute, inpatient, geriatric psychiatric facility, dated 05/24/24, revealed the resident had verbally and physically assaulted a peer. The form indicated Resident #76 had been a direct admit to the facility, and his discharge plan included returning back to the facility if the patient declined voluntary admission.</p> <p>Review of Resident #76's inpatient hospital progress notes revealed a note dated 05/29/24 at 2:53 P.M. authored by a hospital social worker stating a call was placed to the facility social worker to discuss the patient's hospital discharge and his pink slip expiring. Hospital social worker informed the facility social worker the resident would need to return prior to his pink slip expiring, and questioned if the facility would be able to pick the resident up the following day. The facility social worker stated the facility was trying to avoid allowing Resident #76 to re-admit. On 06/14/24, the hospital requested a discharge notice but the facility refused to provide one.</p> <p>Review of Resident #76's medical record revealed no evidence of a 30-day or emergency discharge notice being completed and provided to Resident #76 and/or his representative.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview on 06/25/24 at 12:32 P.M. with Hospital Worker #140 revealed Resident #76 was transported by the facility to the acute, inpatient hospital for a psychiatric stay. The day before Resident #76 was to discharge back to the facility, the facility stated they would not accept Resident #76 back for re-admission. Hospital Worker #140 stated she had been told by the facility there was a formal discharge letter provided to Resident #76 which stated he could not return to the facility, but that later proved to be untrue. Hospital Worker #140 stated Resident #76 remained a patient at the hospital and wanted to return to the facility.</p> <p>An telephone interview on 05/24/24 at 1:28 P.M. with a family member of Resident #76 revealed the family member as angry, stating the resident's discharge situation was not handled correctly. The family member stated Resident #76 never received a discharge notice from the facility, nor did Resident #76.</p> <p>An interview on 06/25/24 at 2:05 P.M. with the Administrator and Director of Nursing (DON) confirmed there had never been a discharge notice provided to the resident or their representative. The Administrator confirmed the facility initially had Resident #76 as a bed hold, but the Administrator decided not to hold the bed with no additional conversation with the resident or the resident's representative.</p> <p>A telephone interview on 06/25/24 at 2:31 P.M. with CNP #210 revealed she oversaw Resident #76's behavior and psychiatric care at the facility. CNP #210 stated other care team members involved with Resident #76's care had encouraged the facility to properly provide Resident #76 with a discharge notice, but to her knowledge the resident or their representative had yet to receive one.</p> <p>Review of the policy titled Permitting Residents to Return to Facility after hospitalization of Therapeutic Leave, dated 10/24/22, revealed not permitting residents to return following hospitalization or therapeutic leave constitutes a facility-initiated discharge and requires a facility to meet additional requirements.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00154903 and Complaint Number OH00154426.</p>

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47990</p> <p>Based on family and staff interview, interview with the Long Term Care Ombudsman, interview with hospital staff, record review, and policy review, the facility failed to allow Resident #76 to return to the facility following a therapeutic leave to an acute, inpatient, geriatric psychiatric facility. This affected one (Resident #76) of three residents reviewed for discharges. The facility census was 75.</p> <p>Findings include:</p> <p>Review of Resident #76's closed medical record revealed an admitted [DATE]. Medical diagnoses included Alzheimer's disease, spinal stenosis, congestive heart failure, and ischemic heart disease. Resident #76 was transferred to an acute, inpatient, geriatric psychiatric facility on [DATE] on a 72-hour involuntary hold placed by Certified Nurse Practitioner (CNP) #210. Resident #76 was previously hospitalized at the same facility from [DATE] to [DATE].</p> <p>Review of Resident #76's Minimum Data Set (MDS) 3.0 discharge return anticipated assessment, dated [DATE], revealed the resident was identified with a memory problem and required modified independence with cognitive skills for daily decision making. Resident #76 was not noted to have any hallucinations, delusions, and was noted to have physical behavioral symptoms directed towards others on one to three days during the seven-day lookback period. Resident #76 was recorded to be independent with eating, and required partial moderate to substantial/maximum assistance with activities of daily living. The resident was occasionally incontinent of urine and was noted to require supervision with mobility tasks.</p> <p>Review of Resident #76's care plan, revised on [DATE], revealed the resident was at risk for complications and side effects from psychotropic drug use. The care plan identified this resident as being followed by a behavioral health team for behavior and medication management. Resident #76 was noted to take routine psychotropic medications and was at risk for continued mood fluctuations, physical decline, and falls. Resident #76 had a history of hitting his call light for no reason, verbally and sexually abusive comments directed towards staff, and at times was inappropriate towards other residents. Listed interventions included acknowledging the resident's feelings and make supportive statements, monitor and document target behaviors/symptoms, provide comfort and support, administer medications as ordered by the physician, and refer to and update the behavioral health team as needed.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #76's interdisciplinary progress notes revealed a note dated [DATE] at 2:48 P.M. which stated Resident #76 was noted in the dining room in his wheelchair with two other residents and a staff member. The resident was noted to be talking in a loud tone with his arms in the air. Resident #76 was removed from the area and questioned what the situation was and stated he was upset. Resident #76 stated he had been attempting to get past another resident who would not move out of his way, and he swatted at her. The resident stated it upset him that the other resident moved chairs in the dining room and that he did nothing wrong. A follow-up note dated [DATE] at 3:02 P.M. revealed the behavioral health provider was updated. A subsequent note dated 5:25 P.M. revealed a new order had been received for Resident #76 to go to an acute, inpatient, geriatric psychiatric facility. The resident was informed of the transfer and was agreeable. The note indicated bed hold obtained but the resident stated he did not like the facility. Resident #76 was transported to the geriatric psychiatric facility by the facility. The facility attempted to phone the resident's emergency contact but there was no answer and a voicemail was left. Prior to [DATE], the resident's only recent aggression recorded in the progress notes included Resident #76 giving a mean look and throwing a newspaper at a staff member during an activity. A follow up note on [DATE] authored by Social Services Director #250 indicated she spoke with the resident regarding the conflict. No additional documentation of behaviors were recorded after the resident readmitted to the facility on [DATE].</p> <p>Review of an Application for Emergency Admission (commonly known as a pink slip) form, dated [DATE] at 3:48 P.M. revealed Resident #76 was noted as a substantial risk of physical harm to others as manifested by evidence of recent homicidal or other violent behavior, evidence of recent threats that place another in reasonable fear of violent behavior and serious physical harm, or other evidence of present dangerousness and would benefit from treatment in a hospital for his mental illness and is in need of such treatment as manifested by evidence of behavior that creates a grave and imminent risk to substantial rights of others or himself. The statement of belief section at the bottom of the form stated Resident #76 demonstrated verbal and physical aggression towards staff and other residents at the facility at which he resides. The form was signed by CNP #210.</p> <p>Review of Resident #76's Behavioral Health Intake form for the acute, inpatient, geriatric psychiatric facility, dated [DATE], revealed the resident had verbally and physically assaulted a peer. The form indicated Resident #76 had been a direct admit to the facility, and his discharge plan included returning back to the facility if the patient declined voluntary admission. The form additionally noted Resident #76 had worsening aggression and had raised his voice at peers.</p> <p>Review of Resident #76's inpatient hospital progress notes revealed a note dated [DATE] at 2:53 P.M. authored by a hospital social worker stating a call was placed to the facility social worker to discuss the patient's hospital discharge and his pink slip expiring. Hospital social worker informed the facility social worker the resident would need to return prior to his pink slip expiring, and questioned if the facility would be able to pick the resident up the following day. The facility social worker stated the facility was trying to avoid allowing Resident #76 to re-admit. A subsequent note dated [DATE] at 8:58 A.M. revealed the hospital social worker attempted to discuss alternate placement options with Resident #76. The resident refused to consider alternate placement options and stated he wanted to remain in [NAME]. The hospital social worker shared with Resident #76 that he may not be able to return to the facility long term and stated she wanted to help him have an alternate place to live. The resident continued to refuse to consider alternate placement. A hospital note dated [DATE] at 1:05 P.M. authored by a hospital nurse revealed Resident #76 was concerned about his wheelchair at the facility and stated he did not want to go back to the facility.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Autumnwood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 670 E Sr 18 Tiffin, OH 44883	
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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #76's medical record revealed no evidence of a 30-day or emergency discharge notice being completed and provided to Resident #76 and/or his representative.</p> <p>A telephone interview on [DATE] at 8:52 A.M. with the facility Ombudsman revealed she had been contacted by the staff at the hospital where Resident #76 was at and was informed the facility would not accept Resident #76 for readmission upon the conclusion of his acute, inpatient stay. The Ombudsman indicated she had emailed and spoken to the facility Administrator who believed the resident's treatment at the hospital was incomplete, and the facility had only received the referral one day prior to the Ombudsman reaching out to the facility.</p> <p>An interview on [DATE] at 9:25 A.M. with the Administrator revealed Resident #76 was transported to the acute, inpatient, geriatric psychiatric facility on [DATE] following an incident of verbal aggression directed at an unnamed resident. The Administrator stated a resident had accidentally stepped on his foot in the dining room and Resident #76 attempted to strike the other resident, but did not make physical contact. The Administrator stated there had been ongoing verbal aggression by Resident #76 towards staff members, and he had a behavioral health team overseeing his care while a resident of the facility. The Administrator indicated Resident #76's transfer to the hospital was initially intended to be short term, and intended for Resident #76 to return back to the facility once stabilized. The Administrator stated that himself and the Director of Nursing (DON) had driven Resident #76 to the hospital on [DATE], at which time Resident #76 verbally stated he wished to be a bed hold. During the interview, the Administrator provided a copy of a progress note documented in Resident #76's hospital record on [DATE] at 5:30 P.M. reflecting the resident having ongoing inappropriate sexual behaviors. The note indicated the resident was yelling and cursing at staff, stating to get the [expletive] out of my room and yelling for cream for his groin. The Administrator was not able to provide any additional examples of ongoing sexual behaviors at the hospital.</p> <p>A telephone interview on [DATE] at 10:55 A.M. with Hospital Worker #100 revealed she was familiar with the circumstances surrounding Resident #76. The resident initially was pink slipped by a provider which also evaluated residents who were inpatient at the geriatric psychiatric hospital. Hospital Worker #100 revealed Resident #76's admission was supposed to be a short-term, temporary admission. After the resident arrived to the hospital, the facility began stating to the hospital that the resident was a threat to others and refused to entertain the idea of him re-admitting to the facility. Hospital Worker #100 stated the referral the facility initially sent reflected no real documentation of behaviors or reason for a pink slip or acute, inpatient treatment. Hospital Worker #100 never heard Resident #76 state that he did not wish to return to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview on [DATE] at 11:28 A.M. with Hospital Worker #115 revealed she was familiar with Resident #76's care and stated it was a clear instance of patient dumping. Hospital Worker #115 stated they have no long term care unit, and no long term beds, and would never have accepted a patient there for long-term care if they had no place to return to. Hospital Worker #115 believed the facility staff exaggerated Resident #76's behaviors, stating it was a stretch to say Resident #76 was aggressive, rather the resident shares his opinions and makes statements of his observations. Hospital Worker #115 stated the resident had consistently voiced that he wished to return to the facility. Hospital Worker #115 stated around the time the resident's pink slip expired (on or around [DATE]), the resident received a call at the facility from an unknown person at the facility stating that if the resident's belongings were not removed from the building, the belongings would be removed from the room. Hospital Worker #115 then stated Resident #76 had phoned his son to retrieve his belongings at the facility. Hospital Worker #115 stated Resident #76 was previously alert and oriented, but over the last few days had been confused related to a recent infection.</p> <p>A telephone interview on [DATE] at 12:32 P.M. with Hospital Worker #140 revealed Resident #76 was transported by the facility to the acute, inpatient hospital for a psychiatric stay. The facility had reported Resident #76 displayed sexually inappropriate behaviors. Before the hospital accepted the patient, since Resident #76 was listed as his own responsible party, the hospital verified the resident would be allowed to return after his pink slip expired, to which the facility Administrator had agreed. Hospital Worker #140 stated they do not require facilities to sign anything, rather it was a verbal agreement. The day before Resident #76 was to discharge back to the facility, the facility stated they would not accept Resident #76 back for re-admission. Hospital Worker #140 explained if Resident #76 did not voluntary sign in to continue care at the acute hospital at the conclusion of the pink slip expiring, the resident would have no where to go. Hospital Worker #140 stated Resident #76 did agree to sign in after discussion with a provider, but stated to hospital staff he had felt coerced, but agreed to stay. Hospital Worker #140 stated she had been told by the facility there was a formal discharge letter provided to Resident #76 which stated he could not return to the facility, but that later proved to be untrue. Hospital Worker #140 stated Resident #76 remained a patient at the hospital and wanted to return to the facility.</p> <p>An interview on [DATE] at 1:07 P.M. with Social Services Director (SSD) #210 revealed the resident made occasional comments in nature, primarily to staff members. SSD #210 stated the comments were not really overtly sexual, but were annoying and rude. SSD #210 recalled receiving a call from the hospital discharge planner questioning if Resident #76 could return. SSD #210 stated she deferred that decision to the Administrator and does not recall the outcome of the conversation, but verified Resident #76 had not readmitted to the facility. SSD #210 went on to describe Resident #76 as not always inappropriate, and described him as being kind, nice and fun. SSD #210 stated she had no knowledge of the resident's family member coming to the facility to clean out his belongings and did not believe anyone at the facility knew the family was going to remove Resident #76's belongings. SSD #210 stated she could not recall the source, but heard rumors that the resident did not wish to return to the facility. SSD #210 stated she never spoke with the resident herself after he transferred to the hospital on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An telephone interview on [DATE] at 1:28 P.M. with a family member of Resident #76 revealed the family member as angry, stating the resident's discharge situation was not handled correctly. The family member indicated Resident #76 had no where to go and was homeless as the facility refused to allow the resident to return to the facility. The family member stated that on the date of the transfer to the hospital, [DATE], an unnamed female resident had wheeled her wheelchair onto his foot in the dining room and sat there. This caused pain to Resident #76's foot, and the resident instinctively reached forward to wheel her off of his foot. Resident #76's family member stated that the facility stated the resident was trying to hit another resident. The family member stated they were not informed of a time frame or estimated length of stay for the hospitalization , but when told Resident #76 had been pink slipped, the family member believed it to be only for a few days,as it had been the time before in [DATE]. The family member reported Resident #76 received a call from an unknown staff member of the facility stating if his room was not cleaned out, the staff would pack up his belongings and store them until further notice. Resident #76 phoned his family member, was upset, and requested the family member retrieve his belongings from the facility, as the resident was fearful his items would turn up missing. Resident #76's family member stated they were confused, as the hospital staff reported to the family they were unsure why Resident #76 had to remain hospitalized and could not return to his home at the facility. The family member stated Resident #76 never received a discharge notice from the facility, nor did Resident #76.</p> <p>An interview on [DATE] at 1:48 P.M. with the Director of Nursing (DON) revealed the resident never struck or assaulted another resident prior to his hospital transport. The DON stated she was unaware why the pink slip indicated Resident #76 assaulted someone and stated that did not happen, nor had the DON ever seen a copy of the pink slip or the hospital intake form. The DON verified the statement on the pink slip and hospital intake form was incorrect, and rather Resident #76 had potentially shown physical aggression by waving his arms around and attempting to strike other residents.</p> <p>An interview on [DATE] at 2:05 P.M. with the Administrator and DON additionally verified Resident #76 did not physically assault another resident and the pink slip form was incorrect. The DON indicated Resident #76's behaviors should be documented in the interdisciplinary progress notes in the electronic medical record, and there was not recent documentation, prior to the hospital transfer on [DATE], of Resident #76 exhibiting verbal, sexual, or physical behaviors, outside of the resident throwing a newspaper during an activity. The DON and Administrator reported Resident #76 as having frequent verbal behaviors, but those were reflected in Resident #76's medical record. The Administrator indicated the facility had intentions of initially taking the resident back, but Resident #76's son showed up randomly to retrieve all his belongings and stated the resident would not return to the facility. The Administrator confirmed there had never been a discharge notice provided to the resident or their representative. The Administrator confirmed the facility initially had Resident #76 as a bed hold, but the Administrator decided not to hold the bed with no additional conversation with the resident or the resident's representative.</p> <p>(continued on next page)</p>		

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<p>F 0626</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview on [DATE] at 2:31 P.M. with CNP #210 revealed she oversaw Resident #76's behavior and psychiatric care at the facility. CNP #210 stated she does a lot of education with the facility, and treatment approaches include non-pharmacological interventions prior to medication use. CNP #210 verified the lack of behaviors documented in Resident #76's medical record at the facility. CNP #210 stated she was initially contacted on the afternoon of [DATE] and told that Resident #76 had been physically and verbally abusive towards another resident, which was why she documented verbally and physically assaulted a resident on the pink slip. CNP #210 stated she found out later that Resident #76 never struck another resident. She stated the initial report of the resident striking another resident made a difference in how she documented and what she based her treatment decisions on. CNP #210 stated other care team members involved with Resident #76's care had encouraged the facility to properly provide Resident #76 with a discharge notice, but to her knowledge the resident or their representative had yet to receive one. CNP #210 stated Resident #76 had voiced his desire to return to the facility.</p> <p>An interview on [DATE] at 3:32 P.M. with Registered Nurse (RN) #225 revealed she was familiar with Resident #76 and described him as ornery and sometimes verbally inappropriate. RN #224 did not believe Resident #76 was or had ever been a risk to himself or others, and stated she did not believe he was dangerous to himself or others.</p> <p>Review of the policy titled Permitting Residents to Return to Facility after hospitalization of Therapeutic Leave, dated [DATE], revealed not permitting residents to return following hospitalization or therapeutic leave constitutes a facility-initiated discharge and requires a facility to meet additional requirements. The policy stated a facility must not discharge a resident unless the discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs; the resident's health has improved sufficiently so that the resident no longer needs the services of the facility; the resident's clinical or behavioral status endangers the health of the individuals in the facility; The resident has failed to pay for his stay at the facility; or the facility ceases to operate.</p> <p>This deficiency represents non-compliance investigated under Master Complaint Number OH00154903 and Complaint Number OH00154426.</p>