STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365380	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumnwood Care Center	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)
F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31638 Based on medical record review, staff interview, and facility policy review, the facility failed to ensure a medication order was complete and accurate and further failed to ensure the medication order was transcribed correctly to make certain Resident #10 was administered the correct medication. Actual Harm occurred when an incomplete verbal order for a critically low potassium level (2.7 milliequivalents per liter [mEq/L] with normal potassium blood serum measuring between 3.5 and 5.5 mEq/L) was transcribed and medication administered inaccurately, resulting in Resident #10 receiving a medication to remove potassium from the blood rather than a medication to replace potassium (low potassium could result in cardiac arrhythmia, numbness, tingling, muscle weakness, spasms, and or muscle damage). Resident #10 required hospital treatment, additional laboratory testing and the replacement of potassium with 40 milliequivalents (mEq) administered orally and 10 mEq intravenously. This affected one (#10) of three residents reviewed for medication errors. The facility census was 81. Findings include: Review of Resident #10's medical record revealed an admitted [DATE]. Diagnoses included Alzheimer's disease, congestive heart failure, and cardiomyopathy. Review of Resident #10's significant change Minimum Data Set (MDS) dated [DATE] revealed a low cognitive function. Resident #10 required a set up for eating. Review of Resident #10's most recent care plan revealed a cardiac diagnosis which required monitoring and medications for congestive heart failure and coronary artery disease. Review of Resident #10's medical record revealed Assistant Director of Nursing (ADON) #200 received a text message (verbal order) from Certified Nurse Practitioner (CNP) #500 on 12/26/24 at 1:16 P.M. stating Resident #10 had critical potassium results. The verbal order stated give 60 mEq now and 60 tomorrow morning and recheck potassium tomorrow a few hours after the morning medication. Review of the order placed by ADON #200 in the electronic medical record dated 12/26/24 at 3:11 P.M. revealed sodium polystyrene sulfonate suspension (Kayexalate) 15 grams per 60 milliliter (ml) was to be administered by mouth one time for hyperkalemia. Review of Resident #10's Medication Administration Record (MAR) dated 12/26/24 revealed Licensed Practical Nurse (LPN) #250 administered sodium polystyrene sulfonate suspension 60 ml by mouth at 4:31 P. M. (continued on next page)

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

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #10's medical record dated 12/26/24 at 5:30 P.M. revealed CNP #500 was updated on a medication error and a new order was obtained to send Resident #10 to the emergency room for evaluation. Resident #10's family was updated on the transfer and Resident #10 was transported to the hospital by the facility van. Review of Resident #10's hospital record dated 12/26/24 revealed the resident was an [AGE] year-old female who presented to the emergency department at 5:51 P.M. for evaluation of possible hypokalemia due to nursing home staff reporting that resident's potassium was low (2.7 mEq/L at 12:43 P.M. per nursing home laboratory test results) and resident was given 60 grams Kayexalate by mistake. Resident #10's potassium level in the emergency department was 2.8 mEq/L, Resident #10 was ordered to receive 40 mEq of potassium orally and 10 mEq intravenously. Resident #10 was discharged and returned to the facility at 11:59 P.M. on 12/26/24 with orders for follow up blood testing to be completed on 12/27/24. Diagnoses included hypokalemia (low potassium) and accidental ingestion of a substance. Review of Resident #10's repeat blood work on 12/27/24 revealed a potassium level of 3.2 mEq/L. Interview with ADON #200 on 01/15/25 at 1:29 P.M. revealed she received a text order from CNP #500 which read critical potassium on Resident #10. Give her 60 mEq right now and 60 tomorrow morning and recheck potassium tomorrow a few hours after the morning medication. ADON #200 revealed she realized her error about an hour after placing the electronic order when she reviewed her text messages and noted the order was not clear. ADON #200 verified she placed an inaccurate order in the electronic medical record for Resident #10. ADON #200 stated when she discovered the error she tried to stop the floor nurse from administering the medication, but was too late, the Kayexalate had already been administered. Interview with the Administrator on 01/16/25 at 3:24 P.M. revealed Resident #10 had low potassium levels and on 12/26/24 CNP #500 had ordered additional potassium to increase the residents potassium level. The Administrator stated ADON #200 misread the incomplete order which was texted to her phone and placed an order for Kayexalate into Resident #10's electronic medical record and once the error was identified Resident #10 was taken to the emergency department for evaluation and was required to receive a potassium infusion. Telephone interview with LPN #250 on 01/21/25 at 1:40 P.M. revealed ADON #200 informed her verbally that Resident #10's potassium was high, and the level needed to be decreased, and an order for Kayexalate had been entered. LPN #250 verified she administered the medication and within a couple of minutes of administering the medication the ADON informed LPN #250 the order was an error. LPN #250 revealed knowledge of Resident #10's history of hypokalemia and verified the resident took a potassium supplement twice daily but had come to the conclusion that her potassium levels must have increased. LPN #250 stated she failed to check the laboratory results herself. Interview with the Administrator on 01/21/25 at 3:10 P.M. revealed the facility failed to have a policy regarding clarification of CNP and physician orders when incomplete. Review of the Medical Director Agreement, signed on 06/18/24 revealed adequate and appropriate services will be provided to residents. Review of the undated facility policy titled Electronic Signatures and Electronic Orders, revealed the facility permits the use of electronic orders in accordance with recognized standards and laws. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the facility policy titled Documentation of New or Changed Physician Prescribed Orders, revised 07/01/24 stated a medication order should include the medication name, strength, dosage, time or frequency and route of administration. This deficiency represents non-compliance investigated under Complaint Number OH00161202.