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	04/22/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review, staff interview, resident interview, and review of facility policy, the facility failed to ensure timely physician notification of medication unavailability for two residents (#10 and #19) of three residents reviewed for physician notification. The facility census was 88.Findings include:1. Review Resident #10's medical record revealed an admission date of 11/20/25, diagnoses included chronic obstructive pulmonary disease (COPD), anxiety disorder, major depressive disorder, asthma, suicidal ideations, and unspecified convulsions.Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 02/09/26 revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #10's cognition was intact. Resident #10 did not have any communication issues and was coded as not having displayed any behaviors during the 14 days of the assessment period. Resident #10 received scheduled antianxiety and antidepressant medications. Review of Resident #10's care plans revealed the resident had an active care plan in place for being at risk for complications related to an anxiety disorder. The care plan was initiated upon admission and was most recently revised on 02/23/26. The goal was for the resident to be free from discomfort or adverse reactions related to anti-anxiety therapy, interventions included to administer medications as ordered and to monitor for side effects and effectiveness every shift.Review of Resident #10's physician's orders revealed the resident had an order to receive Ativan 0.5 milligrams (mg) by mouth twice a day for anxiety and agitation. Review of the Medication Administration Record (MAR) from 04/18/26 through 04/19/26 revealed the evening dose (to be administered between 3:00 P.M. and 6:00 P.M.) on 04/18/26 and the early dose (to be administered between 5:00 A.M. and 10:00 A.M.) on 04/19/26 were not administered. The MAR contained a documented reason for omission as other, see progress note for each missed administration. Review of the progress note dated 04/18/26 at 5:28 P.M. revealed Resident #10's Ativan was not administered as it was unavailable and on order.Review of the progress note dated 04/19/26 at 4:13 A.M. revealed Resident #10's Ativan was not administered as it was unavailable due to waiting on pharmacy to deliver.Interview on 04/19/26 at 10:17 A.M. with Resident #10 revealed the resident has anxiety and depression and the facility had ran out of her Ativan. Interview on 04/19/26 at 10:45 A.M. with Licensed Practical Nurse (LPN) #300 verified Resident #10 had not received her physician ordered doses of Ativan the evening of 04/18/26 or in the morning of 04/19/26. Interview on 04/20/26 at 12:30 P.M. with Nurse Practitioner (NP) #301 revealed missing two doses of Ativan can cause disruption in treatment and increase the resident's anxiety. NP #301confirmed the facility did not notify him of the missed Ativan doses for Resident #10.2. Review of Resident #19's medical record revealed an admission date of 09/23/24, diagnoses included convulsions, anemia, stage four chronic kidney disease, major depressive disorder, syncope and collapse, tremor, cerebral infarction, and seizures.Review of the most recent quarterly MDS assessment, dated 02/08/26, revealed a BIMS score of 15, indicating Resident #19's cognition was intact. Resident #10 did not have any communication issues, had not displayed any behaviors during the 14 days of the assessment period, and was receiving scheduled anticonvulsant medications. Review of Resident #19's care plans revealed the resident had an active care plan in place for being at risk for being on sedative/hypnotic therapy related to convulsions/seizure disorder. The care plan (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

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	04/22/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	was initiated upon the residents' admission and most recently revised on 02/08/26. The goal was for the resident to be free from discomfort or adverse side effects of hypnotic use with interventions that included to administer sedative/hypnotic medications as ordered by physician and to monitor and document side effects and effectiveness every shift. Review of Resident #19's physician's orders revealed the resident had an order to receive Phenobarbital (a medication that slows the activity of your brain and nervous system and is used to treat or prevent seizures) 32.4 mg by mouth every morning for seizures and 129.6 mg in the evening for convulsions. Review of the MAR from 04/17/26 through 04/19/26 revealed the evening doses on 04/17/26 and 04/18/26 (to be administered between 3:00 P.M. and 6:00 P.M.), and the morning dose (to be administered between 5:00 A.M. and 10:00 A.M.) on 04/18/26 were not administered. The MAR contained a documented reason for omission as other, see progress note for each missed administration. Review of the progress note dated 04/17/26 at 5:21 P.M. revealed Resident #19's Phenobarbital was not administered as only one tablet of the two tablet dose was available to administer. Review of the progress note dated 04/18/26 at 12:43 P.M. reveled Resident #19's Phenobarbital was not administered as it was not available. Review of the progress note dated 04/18/26 at 4:12 P.M. revealed Resident #19's Phenobarbital was not administered as it was unavailable and on order.Interview on 04/19/26 at 10:27 A.M. with Resident #19 revealed she had not received her physician ordered doses of Phenobarbital since the morning dose on 04/17/26. Interview on 04/19/26 at 10:45 A.M. with LPN #300 verified Resident #19 did not receive the physician ordered dose of Phenobarbital on the evening of 04/17/26. Additionally, LPN #300 verified Resident #19 did not receive either of the physician ordered doses of Phenobarbital on 04/18/26.Interview on 04/20/26 at 12:30 P.M. with NP #301 confirmed the facility did not notify him of the missed doses.Review of the facility policy titled Change in a Resident's Condition or Status, most recently revised May 2024, indicated the facility is to promptly notify the physician of changes in condition, including inability to administer medications as ordered.This deficiency represents non-compliance investigated under Master Complaint Number 2988837.

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	04/22/2026

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. Based on medical record review, resident interview, observation, staff interview, and policy review, the facility failed to ensure residents were free from significant medication errors and further failed to ensure medications were administered as ordered. This resulted in Actual physical harm and emotional distress for one (#10) resident on 04/19/26 at 10:17 A.M. when Resident #10 verbalized being distraught about not receiving her anti-anxiety medication (Ativan) because the facility had run out and she had not received the evening dose (to be administered between 3:00 P.M. and 6:00 P.M.) on 04/18/26 and the early dose (to be administered between 5:00 A.M. and 10:00 A.M.) on 04/19/26, and she was observed to be shaking, tearful and in emotional distress requiring staff intervention. Additionally, a second resident (#19) did not receive her physician prescribed anticonvulsant medication (Phenobarbital) for the evening doses on 04/17/26 and 04/18/26 (to be administered between 3:00 P.M. and 6:00 P.M.), and the morning dose (to be administered between 5:00 A.M. and 10:00 A.M.) on 04/18/26 as they were not available, placing the resident at potential risk for more than minimal harm. This affected two (#10 and #19) of three residents reviewed for medication administration. The facility census was 88. Findings include:1) Review of Resident #10's medical record revealed an admission date of 11/20/25 with diagnoses including chronic obstructive pulmonary disease (COPD), anxiety disorder, major depressive disorder, asthma, suicidal ideations, and unspecified convulsions.Review of the most recent quarterly Minimum Data Set (MDS) assessment, dated 02/09/26 revealed a Brief Interview of Mental Status (BIMS) score of 15, indicating Resident #10's cognition was intact. Resident #10 did not have any communication issues and was coded as not having displayed any behaviors during the 14 days of the assessment period. Resident #10 received scheduled antianxiety and antidepressant medications. Review of Resident #10's care plans revealed the resident had an active care plan in place for being at risk for complications related to an anxiety disorder. The care plan was initiated upon admission and was most recently revised on 02/23/26. The goal was for the resident to be free from discomfort or adverse reactions related to anti-anxiety therapy, interventions included to administer medications as ordered and to monitor for side effects and effectiveness every shift.Review of Resident #10's physician's orders revealed the resident had an order to receive Ativan (used to treat anxiety disorders and related symptoms by calming the nervous system, reducing physical symptoms [racing heart, muscle tension], and decreasing panic attacks) 0.5 milligrams (mg) by mouth twice a day for anxiety and agitation. Review of the Medication Administration Record (MAR) from 04/18/26 through 04/19/26 revealed the evening dose (to be administered between 3:00 P.M. and 6:00 P.M.) on 04/18/26 and the early dose (to be administered between 5:00 A.M. and 10:00 A.M.) on 04/19/26 were not administered. The MAR contained a documented reason for omission as other, see progress note for each missed administration. Review of the progress note dated 04/18/26 at 5:28 P.M. revealed Resident #10's Ativan was not administered as it was unavailable and on order.Review of the progress note dated 04/19/26 at 4:13 A.M. revealed Resident #10's Ativan was not administered as it was unavailable due to waiting on pharmacy to deliver.During an interview on 04/19/26 at 10:17 A.M. with Resident #10 revealed the resident has anxiety and depression and the facility had run out of her Ativan. Continued observation from 10:17 A.M. until 10:40 A.M. revealed Resident #10 was visibly upset as the resident was shaking and tearful. Licensed Practical Nurse (LPN) #300 responded to Resident #10, assessed the resident, called the physician, set up a telehealth visit for the resident to meet with the provider, and received an order to obtain a dose of Ativan from the facility's back up medication stock. Interview on 04/19/26 at 10:45 A.M. with LPN #300 verified Resident #10 had not received her physician ordered doses of Ativan the evening of 04/18/26 or in the morning of 04/19/26. Further interview with LPN #300 verified Resident #10 was shaking, tearful, and visibly upset and required staff intervention.Interview on 04/19/26 at 11:48 A.M. with the Director of Nursing (DON) verified the facility had nine tablets of Ativan available in the facility's back up stock of (continued on next page)

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	04/22/2026

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.	medications in the medication dispensing machine. The DON stated staff just needed to obtain an order from the physician and a code from the pharmacy to obtain the medication from the machine.Interview on 04/20/26 at 12:30 P.M. with Nurse Practitioner (NP) #301 revealed missing two doses of Ativan can cause disruption in treatment and increase the resident's anxiety.2) Review of Resident #19's medical record revealed an admission date of 09/23/24 with diagnoses including convulsions, anemia, stage four chronic kidney disease, major depressive disorder, syncope and collapse, tremor, cerebral infarction, and seizures.Review of the most recent quarterly MDS assessment, dated 02/08/26, revealed a BIMS score of 15, indicating Resident #19's cognition was intact. Resident #19 did not have any communication issues, had not displayed any behaviors during the 14 days of the assessment period, and was receiving scheduled anticonvulsant medications. Review of Resident #19's care plans revealed the resident had an active care plan in place for being at risk for being on sedative/hypnotic therapy related to convulsions/seizure disorder. The care plan was initiated upon the residents' admission and most recently revised on 02/08/26. The goal was for the resident to be free from discomfort or adverse side effects of hypnotic use with interventions that included to administer sedative/hypnotic medications as ordered by physician and to monitor and document side effects and effectiveness every shift. Review of Resident #19's physician's orders revealed the resident had an order to receive Phenobarbital (a medication that slows the activity of your brain and nervous system and is used to treat or prevent seizures) 32.4 mg by mouth every morning for seizures and 129.6 mg in the evening for convulsions. Review of the MAR from 04/17/26 through 04/19/26 revealed the evening doses on 04/17/26 and 04/18/26 (to be administered between 3:00 P.M. and 6:00 P.M.), and the morning dose (to be administered between 5:00 A.M. and 10:00 A.M.) on 04/18/26 were not administered. The MAR contained a documented reason for omission as other, see progress note for each missed administration. Review of the progress note dated 04/17/26 at 5:21 P.M. revealed Resident #19's Phenobarbital was not administered as only one tablet of the two tablet dose was available to administer. Review of the progress note dated 04/18/26 at 12:43 P.M. reveled Resident #19's Phenobarbital was not administered as it was not available. Review of the progress note dated 04/18/26 at 4:12 P.M. revealed Resident #19's Phenobarbital was not administered as it was unavailable and on order.Interview on 04/19/26 at 10:27 A.M. with Resident #19 revealed she had not received her physician ordered doses of Phenobarbital since the morning dose on 04/17/26. Interview on 04/19/26 at 10:45 A.M. with LPN #300 verified Resident #19 did not receive the physician ordered dose of Phenobarbital on the evening of 04/17/26. Additionally, LPN #300 verified Resident #19 did not receive either of the physician ordered doses of Phenobarbital on 04/18/26.Interview on 04/19/26 at 11:48 A.M. with the DON verified the facility had four tablets of Phenobarbital available in the facilities over ride medication dispensing cabinet. Review of the facility policy titled General Guidelines for Medication Administration, most recently revised August 2020, revealed medications are to be administered as prescribed. The facility has sufficient staff and a medication distribution system to ensure safe administration of mediations without unnecessary interruptions.Review of the facility policy titled, Controlled Substance, most recently revised August 2020, revealed all controlled medications are requested when a minimum of a five-day supply remains, or in accordance with facility policy, to allow for time for acquisition and transmittal of the required original written prescription to the provider pharmacy, if necessary.Review of the facility policy titled, Administering Medications, most recently revised April 2019, revealed medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame.This deficiency represents non-compliance investigated under Master Complaint Number 2988837.