

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/29/2026
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)		
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, staff interview and facility policy review, the facility failed to ensure commons areas on the secured memory care unit were maintained to provide a homelike environment. This affected all 14 residents (#13, #23, #24, #25, #26, #27, #28, #29, #30, #31, #32, #33, #34, and #35) on the memory care unit. The facility census was 89. Findings Include: Observation on 07/27/26 at 4:12 P.M. on the secured unit revealed two common areas where residents watched television or interacted. One was painted a dark green/blue and the paint was missing, exposing white wall, around most of the perimeter of the room approximately at the height where the backs of chairs would rub. Interview on 07/29/26 at 10:35 A.M. with the Administrator, and concurrent observation of the dark painted common room on the memory care unit, confirmed there were several areas of missing paint with scratches and gouges in the wall. The Administrator stated he was not aware the room looked like that and immediately entered a work order for it to be addressed. The Administrator stated the paint could be matched to cover the white areas. Follow-up interview on 07/29/26 at 10:40 A.M. with the Administrator revealed the common room was just repainted approximately six months previously and the removed paint and gouges were new. The Administrator further confirmed the doorframe into the common areas was scratched and the paint was removed. Observation on 07/29/26 at 11:35 A.M. and concurrent interview with Licensed Practical Nurse (LPN) #206 confirmed several areas on the common room with the dark paint were missing paint and had gouges. These resulted in several areas of stark white wall, with ragged paint edges, around the perimeter of the room. On the wall with an opening into the other common room, to the left of the opening approximately two and one half feet up from the ground was an area 20 inches wide and nine inches high void of paint with ragged edges along the paint line. Further to the left was an area approximately 20 inches width and 13 inches high with a cluster of several smaller spots where the paint was removed and there were scratches and gouges in the wall. To the right of the opening was an area approximately 12 inches wide by six inches high with all the paint missing and ragged edges along the paint line. Continued observation and interview of the wall with an opening to the main hallway revealed an area to the right of the opening measuring approximately nine inches wide and six inches tall where all the dark paint was removed, exposing a white area. Further, on the wall opposite the doorway to the main hallway was an area approximately 11 inches wide and 10 inches high with several smaller areas of scratches and gouges exposing white under the paint. LPN #206 confirmed the doorframe into the common room from the main hallway had scratches and paint removed revealing multiple colored layers of paint. LPN #206 stated Resident #30 liked to scratch at the paint and at the doorframes. Review of the policy, Quality of Life - Homelike Environment, revised May 2017, revealed the facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics included (but were not limited to): clean and (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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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	orderly environment, (and) inviting colors and decor. This deficiency represents non-compliance investigated under Master Complaint Number 3118867 and Complaint Number 3107217.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review, staff interview, review of the facility's investigation, and facility policy review, the facility failed to ensure a thorough investigation was completed when a resident was injured during a transfer using a mechanical lift. This affected one (#17) of three residents reviewed for transfers via mechanical lift. The facility census was 89. Findings include: Review of the medical record for Resident #17 revealed an admission date of 08/12/25 with diagnoses of hypoxemia, congestive heart failure, and muscle weakness. Review of the quarterly Minimum Data Set assessment, dated 04/26/26, revealed Resident #17 had impaired cognition and was dependent on staff for chair to bed transfers. Review of Resident #17's care plan, initiated 09/04/25, with revisions, revealed she had activities of daily life self-care and mobility performance deficits related to advanced age with progressive difficulties caring for self, swallowing, and weight loss. Interventions for transfers included: the resident may require total, two staff assist to transfer with Hoyer lift; do not place the lift pad inside her brief. Review of a nursing progress note dated 06/02/26 at 9:23 P.M. revealed Resident #17 had a skin tear to her left upper wrist measuring length of 3 (no unit of measurement identified), no width and no depth. The wound was in-house acquired. Pain level was zero. Further review revealed the area was cleaned with saline, six steri-strips were applied, antibiotic ointment was applied, it was covered with an oil emulsion non-adhering dressing and covered with gauze wrap. Review of the facility's investigation into Resident #17's skin tear as a result from the transfer from a mechanical lift on 06/02/26 revealed a statement from the Director of Nursing (DON) documenting Resident reported she caught her left wrist during a Hoyer transfer and had a small skin tear measured 3 cm (centimeters) by 0.5 cm skin tear. Resident was able to independently move arms and denied wrong doing of staff. Reminded resident to keep arms close to self during transfer to avoid bruises or skin tears in the future. Treatment implemented as ordered. Family and Medical Director notified. Further review of the facility's investigation revealed a witness statement, dated 06/02/26 untimed, typed by Licensed Practical Nurse (LPN) #201 for Certified Nursing Assistant (CNA) #102 stating, writer was informed by STNA (State Tested Nursing Assistant) Resident was being transferred by another STNA and that she heard Resident saying ouch ouch due to Resident's hand being caught in Hoyer lift. Review of an interdisciplinary team progress note, dated 06/03/26 at 1:44 P.M., written by Assistant Director of Nursing #505, revealed the team discussed the skin tear to arm that occurred during transfer with Hoyer (mechanical) lift. Writer spoke with resident regarding Geri-sleeves being placed to arms to help prevent further skin tears and she was agreeable to try them. Placed on resident by writer. Interview on 07/27/26 at 12:35 P.M. with Resident #17 revealed she felt some staff were more rough than others when using the mechanical lift, but Resident #17 could not be specific or provide examples to explain what she meant. Resident #17 could not recall how many staff were present when using the mechanical lift. Interview on 07/28/26 at approximately 3:15 P.M. with the DON revealed CNA #102 and CNA #103 were the two staff who transferred Resident #17 via mechanical lift on 06/02/26, at the time of the incident resulting in Resident #17's skin tear. The DON confirmed two staff should be present when using a mechanical lift. Interview on 07/29/26 at 1:32 P.M. with CNA #102 and concurrent review of the witness statement dated 06/02/26, revealed CNA #102 stated she was not in the room during the mechanical lift transfer of Resident #17 on 06/02/26 resulting in the skin tear. CNA #102 further denied the statement written by LPN #201. Telephone interview on 07/29/26 at 1:46 P.M. with CNA #103 revealed she could not recall if she was present during Resident #17's transfer on 06/02/26 resulting (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in her skin tear. Telephone interview on 07/29/26 at 2:04 P.M. with LPN #201 revealed she had just started her shift on 06/02/26 at approximately 2:00 P.M. (second shift) when Resident #17's family came to LPN #201 at the medication cart requesting an adhesive bandage. LPN #201 said Resident #17's family stated they had previously requested one but had not yet received one. LPN #201 went to examine Resident #17 and saw the skin tear was too large for an adhesive bandage. LPN #201 stated the Nurse Practitioner was there and assessed the area also and confirmed the treatment orders of steri-strips were appropriate. LPN #201 stated she stopped a first shift CNA as she was leaving the facility at the end of first shift and asked her what she knew about the skin tear and typed the statement regarding Resident #17 saying ouch. LPN #201 stated she could not recall the CNA's name. Interview on 07/29/26 at 2:35 P.M. with the DON revealed she spoke with LPN #201 over the phone and had LPN #201 describe the CNA she interviewed for the witness statement. The DON determined the statement was made by CNA #103, not by CNA #102. Further interview with the DON, with review of the witness statement, indicated CNA #103 made the statement Resident #17 was being transferred by another CNA. The DON further stated she had attempted to contact CNA #103 and had not received a return call. Additionally, the DON stated the only other CNA assigned to the hall on first shift on 06/02/26 was CNA #102. The Surveyor informed the DON of an interview with CNA #102 wherein CNA #102 denied being in the room during the transfer. The DON confirmed she could not determine who was present during Resident #17's transfer via mechanical lift on 06/02/26 resulting in a skin tear. Additional review of the facility's investigation, and concurrent interview with the DON on 07/29/26 at 3:40 P.M., revealed LPN #201 was approached by Resident #17's family requesting a Band-Aid (adhesive bandage), and the family stated there was a small area bleeding. LPN #201 noted a 3 cm by 0.5 cm skin tear to left upper wrist. LPN #201 was informed by family and resident that it happened during transfer on a Hoyer lift. Continued interview at that time with the DON confirmed the facility did not complete any additional investigation into the cause of Resident #17's skin tear during a transfer via mechanical lift, including determining which staff were present during the transfer, and what factors contributed to the skin tear. Review of the policy, Accident and Incidents - Investigating and Reporting, revised July 2017, revealed the Nurse Supervisor/Charge Nurse and/or the department director or supervisor shall promptly initiate and document investigation of the accident or incident. Further, the policy revealed: the following data, as applicable, shall be included on the Report of Incident/Accident form: The date and time the accident or incident took place; the nature of the injury/illness; the circumstances surrounding the accident or incident; where the accident or incident took place; the name(s) of witnesses and their accounts of the accident or incident; . other pertinent data as necessary or required. This was an incidental finding identified during the Complaint Survey completed 07/29/26.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, staff interview, and record review, the facility failed to ensure diet orders, including limited fluids, were provided per physician orders. This affected one (#12) of three residents reviewed for specialized diet orders. The facility census was 89. Findings Include: Review of the medical record for Resident #12 revealed an admission date of 07/16/26 with diagnoses of congestive heart failure, fracture of thoracic vertebra, and chronic obstructive pulmonary disease. Review of the nursing admission Assessment, initiated 07/16/26 and completed 07/18/26, revealed Resident #12 was alert and oriented to person, place and time and was ambulatory. Review of a nursing progress note, dated 07/19/26, revealed the physician was notified of family concerns and requests. Orders added for fluid restriction daily of 1800, daily weights and {changing the diet from} NAS (no added salt) to carb controlled diet. Review of Resident #12's diet order, dated 07/21/26, revealed he received a CCHO (consistent carbohydrate)/No Salt Packet diet, regular texture, regular (fluid) consistency, 1800 fluid restriction per 24 hours, 360 per meal 720 milliliters (ml) nursing. Observation during noon meal service in the dining room on 07/28/26 at 11:43 A.M. revealed Resident #12 sitting at a table with a glass of iced tea. Follow-up observation at 11:51 A.M. revealed Resident #12 had an empty glass and also a glass of chocolate milk. Follow-up observation at approximately 12:10 P.M. revealed two empty glasses in front of Resident #12. Interview on 07/28/26 at 12:20 P.M. with Dietary Manager #301 and Registered Dietitian (RD) #303 confirmed Resident #12's meal ticket, provided by the kitchen, did not reflect the physician ordered fluid restriction. RD #303 stated she believed the fluid restriction was a family preference. Interview on 07/28/26 at 12:25 P.M. with Dietary Aide (DA) #101 confirmed she served Resident #12 a glass of iced tea and a glass of chocolate milk. DA #101 stated she was unaware Resident #12 was on a fluid restriction. DA #101 was able to identify the glasses she provided Resident #12 were 240 ml each. Interview and observation on 07/28/26 at 1:10 P.M. with RD #303 and the drinking glasses provided to Resident #12 verified each glass was 240 ml. Review of Resident #12's meal ticket for 07/28/26 revealed he should receive a CCHO/NS (no salt) diet, no salt packets. Regular texture, regular fluid consistency. This deficiency represents non-compliance investigated under Complaint Number 3107217.		