| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365380 | A. Building<br>B. Wing | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Autumnwood Care Center | 670 E Sr 18<br>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) |
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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that residents are free from significant medication errors.<br><br>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<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | 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 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, (continued on next page) |

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| F 0760<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | 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. |

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| F 0577<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many<br><br>Note: The nursing home is disputing this citation. | Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.<br><br>Based on observation, resident interview, and staff interview, the facility failed to ensure state survey results were available without having to request them. Furthermore, the facility failed to ensure notice of the availability of the state survey results were posted in prominent and accessible areas for the residents/public. This had the potential to affect all residents. The facility census was 88.Findings include:Interview on 04/21/26 at 8:38 A.M. with Resident's #15, #19, #25, and #70 revealed they were not aware where the state survey results could be found.Observation on 04/21/26 at 9:45 A.M. of the front lobby, nurses station between the 100 and 200 halls, both dining rooms, the nurse's station between the 300 and 600 halls, and all resident room hallways in the facility revealed no signage posted regarding the location of the state survey results.Interview on 04/21/26 at 9:50 A.M. with Receptionist #280 verified she was unaware of where the state survey results were located and was unaware of any signage posted in the facility regarding the location of the state survey results.Interview on 04/21/26 at 9:51 A.M. with Certified Nursing Assistant (CNA) #228 verified she was unaware of where the state survey results were located and was unaware of any signage posted in the facility regarding the location of the survey results.Interview on 04/21/26 at 9:53 A.M. with the Director of Nursing (DON) verified the state survey results were usually kept in either the hallway or the dining room, however the DON was unaware were the state survey results were located and the DON further verified she was unaware of any signage posted in the facility regarding the location of the state survey results.Interview on 04/21/26 at 9:55 A.M. with the Administrator verified the state survey results were not available in the facility without having to ask a staff member for the state survey results. Furthermore, the Administrator verified he was unaware of any signage posted in the facility regarding the location of the survey results. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interview, review of the Resident Assessment Instrument (RAI), review of the National Institute of Health website, and facility policy review the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded. This affected three residents (#12, #52, and #76) and had the potential to affect six residents (#12, #14, #30, #47, #52, #76) the facility identified as being invasive ventilator dependent. The facility census was 88.Findings include:1. Review of Resident #12's medical record revealed an admission date of 10/16/12. Diagnoses included paraplegia, chronic obstructive pulmonary disease (COPD), obstructive sleep apnea, and dependence on respirator.Review of Resident #12's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident required an invasive mechanical ventilator (Section O, question F1 of the assessment).Review of Resident #12's most recent care plan revealed the resident had altered respiratory status, difficulty breathing related to COPD, obstructive sleep apnea, and diffuse contractures limiting his mobility. The resident wore ventilator/average volume assured pressure support (AVAPS) per orders and was at risk for complications.Review of Resident #12's medical record revealed a physician order dated 04/16/26 for a ventilator/AVAPS AE (auto-titration mode of noninvasive ventilation) VT 425 machine with a maximum of 30 pressure support with an expiratory positive airway pressure (EPAP) of 6/ 15 and a respiratory rate between 10/15 respirations per minute with automatic speed and rise. May titrate settings for patient comfort/tolerance. Every shift for ventilator dependence, daily use required.Observation on 04/20/26 at 1:15 P.M. revealed Resident #12 was sitting in his room free of a tracheostomy or a respiratory ventilator. An AVAP machine was at bedside with a face mask attached.2. Review of Resident #52's medical record revealed an admission date of 01/02/25. Diagnoses included chronic obstructive pulmonary disease, dependence on respirator ventilator status, and obstructive sleep apnea. Review of Resident #52's quarterly MDS assessment dated [DATE] revealed the resident required an invasive mechanical ventilator. Review of Resident #52's medical record revealed a physician's order dated 04/09/26 for a ventilator/AVAPS AE VT - 350 P, maximum of 30 pressure support,10/6 EPAP, and a respiratory rate of 10. May titrate settings for patient comfort/tolerance. Further physician order dated 04/09/26 revealed Resident #52 utilized ventilator/AVAPS for at least one hour during shift. Every shift for ventilator dependence, daily use required. Observation on 04/20/26 at 10:20 A.M. revealed Resident #52 was ambulating per self in her room. She was free of a ventilator or tracheostomy. Interview with Resident #52 on 04/20/26 at 10:20 A.M. revealed the resident does not use a ventilator but does utilize a CPAP (continuous positive airway pressure) machine while sleeping. The CPAP was observed at bedside.3. Review of Resident #76's medical record revealed an admission date of 08/12/22. Diagnoses included chronic obstructive pulmonary disease, obstructive apnea, acute and chronic respiratory status, and acute and chronic respiratory failure with hypoxia.Review of Resident #76's most recent care plan revealed he was respirator/vent dependence. The resident had COPD, morbid obesity, and obstructive sleep apnea with altered respiratory status, difficulty breathing and dependence on AVAP device while sleeping. Review of Resident #76's quarterly MDS assessment dated [DATE] revealed the resident was coded for an invasive mechanical ventilator.Review of Resident #76's medical record revealed a physician's order dated 04/09/26 for a ventilator/AVAPS AE VT- 325 P Max- 25, pressure support, 5-15 EPAP and 5 to 10 respiratory rates. May titrate settings for patient comfort/tolerance. An additional order dated 04/09/26 was to utilize ventilator/AVAPS for ventilator for at least one hour during this shift. Every shift for ventilator dependence. Interview with Licensed Practical Nurse (LPN) #300 on 04/20/26 at 10:10 A.M. revealed Resident #76 failed to have an invasive ventilator but utilized a CPAP at night. Observation of Resident #76 on 04/20/26 at 10:13 A.M. revealed he was sitting in a wheelchair in the lounge napping. The resident was free of any mechanical ventilation.Interview with MDS Nurse #152 (continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | on 04/21/26 at 12:28 P.M. revealed the physician utilized AVAPs so they were coding them according to the Resident Assessment Instrument (RAI) definitions. MDS Nurse #152 stated closed loop systems should be coded as invasive ventilators. The education the MDS nurse received revealed AVAPS continually monitored the resident and adjusts the volume as needed based off the predefined settings ordered due to the resident not being able to support their own respirations.Interview with the Ohio Department of Health Resident Assessment Instrument (RAI) and Outcome and Assessment Information Set (OASIS) Education Coordinator on 03/31/26 revealed the average volume-assured pressure support (AVAPS) is a non-invasive ventilation that integrates the characteristics of both volume and pressure-controlled non-invasive ventilation. AVAPS is most closely aligned with BiPAP and should be coded at O0110G2, BiPAP when used during the look-back period.A National Institute of Health StatPearls available at https://www.ncbi.nlm.nih.gov/books/NBK560600/ has an article titled Average Volume-Assured Pressure Support, that states different modalities of non-invasive ventilation exist, with continuous positive airway pressure (CPAP) and bilevel positive airway pressure (BiPAP) being the most commonly used modes.Review of the RAI manual coding instructions for Invasive Mechanical ventilator (ventilator or respirator) revealed: code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensures adequate ventilation in the resident who is or who may become (such as during weaning attempts) unable to support their own respiration in this item. During invasive mechanical ventilation the resident's breathing is controlled by the ventilator. Residents receiving closed-system ventilation include those residents' receiving ventilation via an endotracheal tube (e.g., nasally or orally intubated) or tracheostomy. A resident who has been weaned off of a respirator or ventilator in the last 14 days or is currently being weaned off a respirator or ventilator, should also be coded here. Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP.Review of the facility policy titled Resident Assessments undated revealed a comprehensive assessment of every resident's needs is made at intervals designated by OBRA and PPS requirements. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, staff interview, and review of facility policy, the facility failed to ensure medications were properly stored and labeled in accordance with professional standards. This had the potential to affected all facility residents. The facility census was 88.Findings include:1. Observation 04/19/26 at 8:22 A.M. of the medication storage cart for the 300-hall revealed an opened 24-ounce bottle of chocolate syrup approximately two-thirds empty, an opened 16-ounce bottle of Geri-Tussin (a liquid cough medicine), lot number F25103, approximately one-half empty, with a manufacturer's expiration date of 05/27, and an opened 16-ounce bottle of Milk of Magnesia, lot number DMR0388, approximately one-half empty, with a manufacturer's expiration date of 05/27 all without an open dates. Additionally, in the medication cart there was one three milliliter (mL) Lantus (a long acting insulin) pen, lot number 6F0555A, labeled for Resident #37, approximately one-half empty, with a manufacturer's expiration date of 09/30/28, the pen was labeled as opened on 03/14/26.<br><br>Concurrent interview at the time of the observation with Licensed Practical Nurse (LPN) #302 revealed per facility policy, all medications should be labeled with an open date. LPN #302 verified the chocolate syrup, the Geri-Tussin, and the Milk of Magnesia where not labeled for when they were opened. LPN #302 also revealed that insulin pens are only good for 28 days after opening if they are stored at room temperature. LPN #302 verified the Lantus insulin pen for Resident #37 was dated as being opened on 03/14/26.<br><br>2. Observation on 04/20/26 at 1:11 P.M. of the 100-hall medication cart revealed a 1000 tablet bottle of 325 milligram (mg) tablets of acetaminophen (a medication used to treat pain and reduce pain), lot number 101Y06, was opened and approximately two-thirds full with a manufacturer's expiration date of 02/27, and a 17.9 ounce bottle of clear lax, (osmotic laxative used to treat occasional constipation by drawing water into the colon to soften stool and increase bowel movement frequency), lot number 5JR0420, approximately one-half full, with a manufacturers expiration date of 06/28 opened and undated.<br><br>Concurrent interview with LPN #185 verified the acetaminophen and the bottle of clear lax were opened and undated. LPN #185 revealed, per facility policy, all medications are be labeled with the date which they are opened.<br><br>3. Observation of the medication storage room revealed a one bottle of tuberculin purified protein derivative, lot number 95156, approximately one-half full, with a manufacturer's expiration date of 09/27, not labeled with an open date. Interview with LPN #185 at the time of the observation verified the tuberculin bottle was not labeled with an open date and further verified per facility, all multi-dose bottles of testing solution are to be labeled with the date for which they are opened.<br><br>Review of the manufacturers package insert for tuberculin purified protein derivative, revealed a vial of tuberculin purified protein derivative which has been entered and in use for 30 days should be discarded.<br><br>Review of the Lantus manufacturers package insert stated the Lantus pen is to be discarded after being stored 28 days at room temperature.<br><br>Review of the facility policy titled, Medications with Shortened Expiration Dates, dated June 2024, (continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | revealed once opened, Lantus Pen, expire 28 days after first use or removal from refrigerator, whichever comes first.<br><br>Review of the facility policy titled Medication Labels, dated September 2018, revealed medications are labeled in accordance with facility requirements.<br><br>Review of the facility policy titled, Vials and Ampules of Injectable Medications, dated September 2024, vials and ampules of injectable medications are used in accordance with manufacturers recommendations or the provider pharmacy's directions for storage, use, and disposal. Unopened vials expire on the manufacturer's expiration date. Opening a vial triggers a shortened expiration date that is unique for that product. The date opened and this triggered expiration date are important to record on multi-dose vials. At a minimum, the date opened must be recorded. Triggered expiration dates may be found in the manufacturer's package insert, on the package provided, or on a reference chart by the pharmacy, or by contacting the pharmacist. Medication in multi-dose vials may be used until the manufacturer's recommended expiration date if inspection reveals no problems during that time. USP <797> guidelines recommend discarding multi-dose vials 28 days after opening. The date opened and the triggered expiration date should be recorded on a label for such purpose and affixed to the vial.<br><br>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. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation, staff interview, resident interview, review of the test tray, and policy review, the facility failed to provide palatable food. This had the potential to affect 87 residents who receive food from the kitchen. The facility identified one resident (#1) who received nothing by mouth. The facility census was 88. Findings include:Observation on 04/19/26 at 12:13 P.M. revealed a test tray to be prepared in the kitchen. The test tray included ravioli in a red sauce, green beans, a breadstick, and Jello poke cake per the menu. At 12:14 P.M. the test tray was placed on the Memory Care meal cart. At 12:16 P.M. the Memory Care meal cart left the kitchen. At 12:18 P.M. the meal cart arrived at the Memory Care unit. At 12:19 P.M. two Certified Nursing Assistants (CNAs) began to pass the meal trays to the Memory Care unit residents. At 12:25 P.M. the final tray on the meal tray cart was passed.Observation on 04/19/26 at 12:30 P.M. of the test tray revealed a colorful and appetizing appearance however the ravioli was cold and lacked flavor, the green beans were cold, and unseasoned. Neither the ravioli or the green beans were palatable. The breadstick and Jello poke cake were flavorful.Interview after the sample of the test tray on 04/19/26 at 12:32 P.M. with Licensed Practical Nurse (LPN) #302 verified the ravioli and green beans were not palatable.Interview on 04/21/26 at 4:17 P.M. with Resident #30 verified the ravioli and green beans served on 04/19/26 were unpalatable. Furthermore, Resident #30 stated when she received her meal, the ravioli and green beans were cold.Review of the facility policy with a last revision date of October 2017 titled Food and Nutrition Services revealed food and nutrition staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe an appetizing temperature. |

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|---|---|---|---|
| | 365380 | A. Building<br>B. Wing | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumnwood Care Center | 670 E Sr 18<br>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.

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|---|---|
| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>Based on observation, staff interview, and policy review, the facility failed to ensure residents on the Memory Care unit preferences regarding meals were identified and honored. This affected 15 residents (#9, #11, #16, #18, #33, #35, #48, #55, #56, #58, #60, #61, #76, #81, and #83) who resided on the Memory Care unit and received food from the kitchen. The census was 88.Findings include:Observation on 04/19/26 at 11:30 A.M. of meal service and meal tray preparation for the meal trays for the 100, 200, 300 and 400 halls revealed each resident's meal ticket contained the resident's name, diet order, allergies, preferences, dislikes and the alternate food items selected for the meal.Continued observation on 04/19/26 at 12:02 P.M. of meal service and meal tray preparation for the Memory Care unit revealed the Memory Care unit resident meal tray tickets contained the resident's name, diet order, and allergies. The meal ticket did not outline resident preferences, dislikes or alternate food items.Interview on 04/19/26 at 12:04 P.M. with Dietary Manager #181 verified the residents on the Memory Care unit meals tickets did not contain preferences or disliked food items as the residents are not asked because they are unable determine what they want each meal. Dietary Manager #181 stated the residents on the Memory Care unit receive the meal as posted. Dietary Manager #131 verified all other residents in the facility, not on the Memory Care unit, are able to determine what they want at each meal, and the staff mark the meal ticket accordingly. Interview on 04/19/26 at 4:03 P.M. with Certified Nursing Assistant (CNA) #240 verified the residents on the Memory Care unit do not preferences or dislikes posted on the meal tickets. CNA #240 stated Resident #56 and Resident #58 had certain food preferences, and those preferences are not honored. CNA #240 stated she has told the kitchen staff about the residents' preferences and they continue to only send the posted meal.Review of the facility policy revised July 2017 titled Resident Food Preferences, stated individual food preferences will be assessed by the Dietician or nursing staff upon admission (within 72 hours) and communicated to the interdisciplinary team. When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. Additionally, the Food Services Department will offer food choices for each scheduled meal, as well as access to nourishing snacks throughout the day and night.Review of the facility policy last revised on October 2017 titled Food and Nutrition Services, revealed each resident is provided with a nourishing, palatable, well-balanced diet taking into consideration the preferences of each resident. Furthermore, reasonable efforts will be made to accommodate resident choices and preferences. |

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| Autumnwood Care Center | 670 E Sr 18<br>Tiffin, OH 44883 |

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|---|---|
| F 0809<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.<br><br>Based on resident interview, staff interview, and policy review, the facility failed to ensure snacks were available and offered to residents. This had the potential to affect 87 residents who were able to receive snacks. The facility identified one resident (#1) as receiving nothing by mouth. The facility census was 88.Findings include:Interview with Resident #31 on 04/19/26 at 9:25 A.M. revealed the resident felt meals were served too close together. Resident #31 stated dinner was served at 4:00 P.M. and no snacks were offered or served in the evening, which left her hungry by breakfast. Interview on 04/21/26 at 8:38 A.M. with Residents #15, #19, #25, and #70 during the Resident Council meeting revealed Resident #15 and Resident #70 had never been offered snacks by the staff. Resident #25 stated if he wanted a snack, he had to ask for it, and the staff would go and get the snack. Resident #19 stated the staff did not offer them evening snacks.Interview on 04/21/26 at 10:01 A.M. with Certified Nursing Assistant (CNA) #278 verified the CNAs were responsible for the snacks being passed. CNA #278 stated the dietary staff were supposed to re-stock the coffee bar with snacks every day but that does not always happen. CNA #278 stated there is coffee bar between the 300 and 400 halls and another one between the 100 and 200 halls is snacks are available. Observation of the coffee bar between the 300 and 400 halls with CNA #278 was empty and contained no snacks.Interview on 04/21/26 at 10:05 A.M. with CNA #277 verified the CNAs are responsible for passing the snacks. CNA #277 stated the CNA's do not ask residents if they want snacks, but provide a snack is one is requested. Observation of the coffee bar between the 100 and 200 halls was empty and contained no snacks. Interview on 04/19/26 at 4:03 P.M. with CNA #240 verified the facility rarely stocks the Memory Care unit with snacks. CNA #240 stated they cannot provide snacks to the residents of the Memory Care unit because they are usually not available. Review of the facility policy last revised July 2017 titled Frequency of Meals, revealed nourishing snacks will be available for residents who need or desire food between meals and evening snacks will be offered routinely to all residents. The facility will choose what snacks are served at bedtime, however, the Dietician and Food Services Manager will solicit input from the residents and/or the Resident Council. Review of the facility policy revised July 2017 titled Resident Food Preferences, stated the Food Services Department will offer food choices for each scheduled meal, as well as access to nourishing snacks throughout the day and night. |

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| Autumnwood Care Center | 670 E Sr 18<br>Tiffin, OH 44883 |

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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, staff interview, and policy review, the facility failed to ensure food that was open was properly stored. Furthermore, the facility failed to ensure eggs that were served undercooked were pasteurized. This had the potential to affect all 87 residents who received food from the kitchen, the facility identified one resident (#1) as receiving nothing by mouth. The facility census was 88. Findings include:Observation on 04/19/26 at 8:19 A.M. of reach in freezer #1 revealed sausage links, zucchini, two bags of biscuits, hash browns, Tator tots, chicken wings, and garlic bread all to be opened and undated.Interview on 04/19/26 at 8:22 A.M. with Dietary Manager (DM) #181 verified the sausage links, zucchini, two bags of biscuits, hash browns, Tator tots, chicken wings, and garlic bread were open in reach in freezer #1 and were undated.Observation with concurrent interview with DM #181 on 04/19/26 at 8:24 A.M. verified in the walk in refrigerator the eggs used in the facility were not pasteurized. Further observation with concurrent interview with DM #181of the walk in freezer revealed chicken patties and waffles were opened and undated.Interview on 04/19/26 at 11:37 A.M. with Dietary Aide (DA) #230 revealed residents were able to request how they wanted their eggs cooked including over-easy eggs.Observation on 04/22/26 at 7:06 A.M. of reach in freezer #1 revealed a bag of lima beans and a bag of onions were opened and undated.Interview on 04/22/26 at 7:07 A.M. with DM #181 verified the bag of lima beans and the bag of onions were opened and undated.Interview on 04/22/26 at 8:11 A.M. with DA #173 verified she was preparing three over-easy eggs for Resident #36. Concurrent observation revealed the facility served the three over-easy eggs to Resident #36.Review of the facility policy with a last revision date of July 2014 titled Preventing Foodborne Illness - Food Handling, revealed the facility recognizes critical factors implicated in foodborne illnesses and the primary focus focuses on preventative measures to minimize the risk to residents. All employees who handle, prepare or serve food will be trained in the policies of safe food handling. Any potentially hazardous foods will be cooked to the appropriate internal temperatures and held at those temperatures for the appropriate length of time to destroy pathogenic microorganisms. |

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| F 0925<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some<br><br>Note: The nursing home is disputing this citation. | Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.<br><br>Based on observation, staff interview, review of the exterminator reports, and policy review, the facility failed to ensure effective pest control. This had the potential to affect 15 residents (#9, #11, #16, #18, #33, #35, #48, #55, #56, #58, #60, #61, #76, #81, and #83) residing on the Memory Care unit. The census was 88.Findings include:Observation on 04/21/26 at 10:11 A.M. of the Memory Care snack cabinet revealed mouse droppings to be on the shelves and at the bottom of the cabinet. Furthermore, a loaf of bread contained in the cabinet had a hole in the bag that appeared to be chewed through and some of the loaf of bread appeared to have small bite marks.Interview on 04/21/26 at 10:21 A.M. with Licensed Practical Nurse (LPN) #307 verified there were approximately 42 mouse droppings in the Memory Care snack cabinet. LPN #307 was unsure how long the mouse dropping had been in the cabinet and was not aware of when the last time the snacks from the cabinet were given to the residents.Review of the exterminator report dated 03/11/26 revealed the facility had treated for rats/mice in public areas, common areas and the south nurse's stations as it was documented that mice were sighted in the 600 hall and the south nurse's station. Review of the exterminator report dated 04/21/26 revealed the facility had general pest control treatment completed in the kitchen, dining room, public/common areas, laundry, therapy room, dishwashing area, dry goods storage, vending machina area, and near exit doors. The comments section read Performed routine service to all marked areas. Spoke with the Executive Director regarding the mouse situation at the south nurse's station near the 600 hallway and the Executive Director states that the issue has been resolved. Further review of the exterminator reports dated 03/11/26 and 04/21/26 revealed no evidence of the Memory Care unit having mice or being treated for mice. Review of the facility policy with a last revision date of May 2008 titled Pest Control revealed the facility shall maintain an effective pest control program to ensure that the building is kept free of insects and rodents. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy the facility failed to ensure a resident who was determined unable to self-administer medications did not self-administer nebulizer treatments. This affected one (#04) of one resident reviewed for medication self-administration. The facility census was 88. Findings include:Review of Resident #04's medical record revealed an admission date of 09/09/25. Diagnoses included acute renal failure, chronic obstructive pulmonary disease, and schizophrenia.Review of Resident #04's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognitive function was intact and that the resident required set up or clean up assistance for eating.Review of Resident #04's most recent care plan revealed the resident suffered from schizophrenia which affected the thought process. Medications were to be administered as ordered.Review of Resident #04's physician order for Ipratropium - Albuterol solution 0.5-2.5 milligrams (mg) per three milligrams solution stated three mgs was to be inhaled orally via nebulizer every six hours as needed for wheezing and shortness of breath and inhale orally via nebulizer two times a day for cough and congestion.Review of Resident #04's physician's order dated 04/16/26 stated to check lung sounds, pulse rate and oxygen saturation levels before and after the nebulizer treatment and for the staff to document the amount of minutes for set up and cleanup of equipment.Observation on 04/19/26 at 9:59 A.M. revealed Resident #04 had a one dose vial of Ipratropium - Albuterol solution and was placing it in the nebulizer without nursing supervision.Review of Resident #04's medical record revealed no evidence of an order for Resident #04 to self-administer medication.Review of Resident #04's medication self-administration assessment revealed Resident #04 was not able to self-administer medication.Interview with Licensed Practical Nurse #302 on 04/19/26 at 10:05 A.M. revealed Resident #04 was particular regarding the nebulizer treatment, so nursing would provide the aerosol treatment dose and allowed the resident to administer the treatment. The nurse verified Resident #04 failed to have an order to self-administer medication.Review of the facility policy titled Administration Procedure for All Medications revised 08/20 revealed medications will be administered in a safe and effective manner. The guidelines in this policy apply to all medications. |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>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.<br><br>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 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<br>(continued on next page) |

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | 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. |

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|---|---|
| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, medical record review, and facility policy review revealed the facility failed to ensure dependent residents received proper grooming. This affected two (#56, #85) of four residents reviewed for assistance of daily living (ADL) care. The facility identified all residents residing in the facility as being dependent for ADL care. The facility census was 88.Findings include:Review of Resident #56's medical record revealed an admission date of 01/08/25. Diagnoses included Alzheimer's disease, dementia, suicidal ideations, anxiety, and amaurosis fugax (vision loss).Review of Resident #56's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a low cognitive function and required partial to moderate assistance regarding personal hygiene and showering.Review of Resident #56's most recent care plan revealed the resident suffered from an activity of daily living (ADL) self-care and mobility performance deficit related to severe cognitive impairment, impaired standing balance, decreased safety awareness, and limited activity tolerance and endurance. Interventions included for moderate assistance of one staff member for personal hygiene, grooming and hygiene tasks.Review of Resident #56's progress notes dated 03/01/26 through 04/21/26 revealed no mention of the resident refusing care.Observation of Resident #56 on 04/19/26 at 10:25 A.M revealed the resident had long nasal hair protruding outside of the resident's nostrils approximately one third of an inch.Attempted interview with Resident #56 was unsuccessful due to low cognition. Interview on 04/19/26 at 10:52 A.M. with Licensed Practical Nurse (LPN) #303 confirmed Resident #56 was in need to have nose hair trimmed. LPN #303 stated that she noticed the nasal hairs that morning and was looking into it as the hair from the resident's nose should have been trimmed on shower days.2. Review of Resident #85's medical record revealed an admission date of 01/01/26. Diagnoses included acute respiratory failure and pulmonary embolism. Review of Resident #85's MDS revealed the resident required substantial/maximum assistance for bathing and required moderate assistance for personal hygiene. Review of Resident #85's most recent care plan revealed the resident had a self-care deficit related to acute illness. The resident required staff assistance for grooming and personal hygiene.Observation on 04/20/26 at 7:10 A.M. revealed Resident #85's finger nails were long and extending approximately 1/2 an inch from his fingertips. Concurrent interview with Resident #85 revealed he does not like having long nails and that staff fail to trim his nails and that he normally had to wait for his sister to visit to receive nail care. Interview with Certified Nursing Assistant (CNA) #265 on 04/22/26 at 9:15 A.M. confirmed Resident #85's finger nails were long and in need of trimming. CAN #265 stated the resident was on Hospice care but added staff are to complete nail care on shower days. Interview with the Director of Nursing (DON) on 04/22/26 at 2:20 P.M. verified facility staff were required to complete resident ADL care even if they were also cared for by hospice staff. Review of the facility policy titled Activities of Daily Living (ADLs), Supporting undated revealed residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. |