STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365563	A. Building B. Wing	11/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumnwood Nursing & Rehab Center	275 East Sunset Drive Rittman, OH 44270

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	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39333 Based on interviews, record review, and review of the facility policy, the facility failed to timely notify Resident #61's alternate Power of Attorney (POA) of a decline in health status when primary POA could not be reached. This affected one resident (Resident #61) of three residents reviewed for notification of change. The facility census was 60. Findings include: Review of the medical record for Resident #61 revealed an admitted [DATE] and a discharged date of 09/26/24 with diagnoses including but not limited to atherosclerotic heart disease, hypothyroidism, and chronic obstructive pulmonary disease. Review of the comprehensive Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #61 had moderately impaired cognition and required supervision with set-up assistance for activities of daily living. Further review of the MDS revealed he was on hospice. Review of the physician's orders for September 2024 revealed the resident was on hospice and was on droplet precautions. Review of Resident #61's admission paperwork revealed a State of Ohio Health Care Power of Attorney (POA) dated 03/25/20 which stated Resident #61's sister as primary agent of POA. The declaration also stated that if the primary agent should not be immediately available, then Resident #61's niece was an alternate agent. Review of the profile tab in Resident #61's medical record revealed Resident #61's niece was not identified as the alternate contact. Review of the nurses' note dated 09/26/24 at 2:06 P.M. revealed Resident #61 had visible change in condition and was transitioning to end of life. Hospice nurse was notified and comfort medication orders to be put in place. Power of Attorney (POA) called, and voicemail left to call back to update on condition. House physician notified. Modeling to below lower extremity noted, apneal breathing using accessory muscles noted and not responding to verbal or painful stimuli. Will update if any change noted. (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
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 11/03/24 at 11:59 A.M. with the Administrator revealed that the hospital liaison sent the information to Former Admissions Director (FAD) #300. FAD #300 would have uploaded the documents into the electronic chart, alerted staff and typed the information into the profile tab of the electronic medical record. A phone interview on 11/03/24 at 12:02 P.M. with FAD #300 verified remotely that no second emergency contact or POA was on the profile page of the electronic chart for Resident #61. FAD #300 stated she did not put the emergency contacts in the electronic chart because she gave admission paperwork to the nursing staff. FAD #300 stated the nurse who admitted the resident should have put emergency contacts in the computer. Interview on 11/03/24 at 12:11 P.M. with the Director of Nursing (DON) and the Administrator verified that Resident #61's second emergency contact was not notified of the change in condition because the information about the second emergency contact, the niece of Resident #61, was not identified. Interview on 11/03/24 at 1:45 P.M. with Licensed Practical Nurse (LPN) #255 verified that no emergency contact was identified for Resident #61. LPN #255 stated that a daughter gave her the numbers, but she did not assign any contact information and did not look at POA because she was assessing the resident and doing the pertinent things that needed to be done by a nurse upon admission. Review of the facility policy titled, Notification of Changes revised May 2017 revealed that our facility shall promptly inform the resident, consults the resident's physician, and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. This deficiency represents non-compliance investigated under Complaint Number OH00159009.