

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365563	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/27/2025
NAME OF PROVIDER OR SUPPLIER Autumnwood Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure equipment used for residents' activities of daily living (ADLs) were maintained in good working condition. This affected one resident (#26) of one resident reviewed for equipment and had the potential to affect one additional resident (#8) who utilized a shower bed for bathing. The facility census was 54.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #26 revealed a readmission date of 11/23/22. Diagnosis included chronic diastolic congestive heart failure (CHF) and morbid severe obesity.</p> <p>Review of the care plan dated 07/19/24 revealed Resident #26 required assistance for activities of daily living (ADLs). Interventions included Resident #26 was totally dependent and does not participate in any aspect of the task for bathing.</p> <p>Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #26 was cognitively intact. Resident #26 had an impairment to both sides of the lower extremities and was dependent on staff for showers and bathing.</p> <p>Interview on 05/12/25 at 7:35 A.M. Resident #26 revealed she cannot take a shower because the facility's shower bed was broke. Resident #26 stated, They do give me bed baths, but I really would prefer a shower. Observation revealed Resident #26's hair was oily.</p> <p>Interview on 05/15/25 at 8:58 A.M. with Certified Nursing Assistant (CNA) #517 revealed Resident #26 was unable to take a shower because the wheels on the shower bed was broken, they kept getting stuck and were unusable. CNA #517 estimated the shower bed had been broken for the approximately two or three months. She had previously informed the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON).</p> <p>Observation of the shower bed located in the North Shower room revealed the shower bed was against the wall. CNA #517 revealed the bed can be moved if there was no weight on it but as soon as a resident laid on it, it would not move.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/15/25 at 9:03 A.M. with ADON #519 revealed Resident #26 used to take a shower using the shower bed, and so did Resident #8, until the bearings on the shower bed broke. ADON #519 revealed, It's been weeks, they wanted to try to replace the bearings before buying a new bed. ADON #519 confirmed Residents #26 and #8 were only getting bed baths because that was the only bariatric shower bed the facility had.</p> <p>Interview on 05/15/25 at 9:10 A.M. with Maintenance Director #610 revealed the bearings in the wheels of the shower bed were worn out and stated, I have to change them, it's been about a month, they came in, I just have to get in there to do it.</p> <p>Record review and interview on 05/19/25 with DON of Resident #26's Shower records revealed Resident #26 was last showered around 02/23/25 and bed baths began on 02/26/25. The DON confirmed that was about the time the shower bed broke and Residents #26 and #8 were no longer able to take a shower.</p>		

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<p>F 0576</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>Based on residents' interview, staff interview, and review of the facility policy, the facility failed to ensure residents received mail on the weekends. This had the potential to affect residents residing in the facility. The facility census was 54.</p> <p>Findings include:</p> <p>Interviews on 05/14/25 at 1:05 P.M. during resident council meeting with Residents #4, # 7, #13 and #34 revealed mail was not delivered on the weekends, only Monday through Friday.</p> <p>Interview on 05/11/24 at 11:13 A.M. with Activities Director (AD) #515 verified resident mail is not always delivered on the weekend. AD #515 further stated that the manager scheduled on the weekend should be delivering the residents their mail during the weekend.</p> <p>Review of the policy Resident Rights revealed the resident had the right to send and receive mail, and to receive letters, packages, and other materials delivered to the facility for the resident thought a means other than a postal service including privacy of such communication consistent with this section, and access to stationary, postage, and writing implements at the resident's own expense.</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents had accurate advance directive orders and information in place throughout the medical record for Resident #45. This affected one resident (#45) of 34 residents reviewed for advance directives. The facility census was 54.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #45 revealed an admission date of 02/28/25 with diagnoses to include but not limited to Alzheimer's Disease, bipolar disorder, and post-traumatic stress disorder.</p> <p>Review of the physician's orders for Resident #45 revealed an order dated 02/28/25 for a Do Not Resuscitate Comfort Care Arrest (DNRCC-A) code status (meaning invasive or extreme life-supporting measures were allowed under any circumstance except for cardiac or respiratory arrest. In the event of cardiac or respiratory arrest only comfort measures would be initiated).</p> <p>Review of the plan of care dated 03/04/25 for Resident #45 revealed the resident was a DNRCCA.</p> <p>Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE] revealed Resident #12 was severely cognitively impaired and required substantial assistance for activities of daily living.</p> <p>Review of the hard medical chart for Resident #45 revealed an unsigned Do Not Resuscitate Comfort Care-Arrest (DNRCCA) code status.</p> <p>Interview on 05/13/25 at 7:35 A.M. with Director of Nursing (DON) verified that Resident #45's DNRCC-A was not signed by a physician. The DNRCC-A paper only had Resident #45's name on it.</p> <p>Review of the facility's policy dated 06/01/24 titled, Resident Rights Regarding Treatment and Advance Directives, revealed it is the policy to support and facilitate a resident's right to discontinue medical treatment and formulate an advance directive.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Review of the medical record for Resident #2 revealed an admission date of 04/25/10 and a readmission date of 03/23/20 with diagnoses to include but not limited to heart failure, chronic obstructive pulmonary disease, and diabetes mellitus.</p> <p>Review of the quarterly Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #2 was cognitively intact and was independent for activities of daily living.</p> <p>An interview on 05/12/25 at 11:08 A.M. with Resident #2 revealed that the heater in his room did not work.</p> <p>Observation during a tour of the facility with the Director of Maintenance (DM) #502 on 05/12/25 at 11:19 A.M. revealed the air temperature in Resident #2's room was 69 degrees F. DM #502 verified the air temperature at the time of observation.</p> <p>3. Review of the medical record for Resident #45 revealed an admission date of 02/28/25 with diagnoses to include but not limited to Alzheimer's Disease, bipolar disorder, and post-traumatic stress disorder.</p> <p>Review of the Minimum Data Set (MDS) 3.0 admission assessment dated [DATE] revealed Resident #12 was severely cognitively impaired and required substantial assistance for activities of daily living.</p> <p>Observation during a tour of the facility with the Director of Maintenance (DM) #502 on 05/12/25 at 11:21 A.M. revealed Resident #45's air room temperature was 68 degrees F. DM #502 verified the air temperature at the time of observation. DM #502 confirmed the heater coils in some rooms have been broken since November 2024. DM #502 confirmed the facility just kept the doors to the residents' rooms open to maintain heat in resident rooms.</p> <p>Interview on 05/13/25 at 11:57 A.M. with the Administrator revealed that the heating and cooling system in the facility circulated water through the registers. He stated that to fix the registers, the heat in the entire building would have to be shut off, and it is on DM #502's schedule to be completed when it is warmer, but before it's too hot.</p> <p>Review of the facility policy titled, Safe and Homelike Environment revised 06/01/24 revealed in accordance with resident rights, the facility will provide a safe, clean, comfortable and homelike environment; includes but not limited to preventing the spread of disease-causing organisms by keeping residents care equipment clean and properly stored. Resident's care equipment includes, but is not limited to , equipment used in the completion of the activities of daily living. The facility will maintain comfortable and safe temperature levels.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163020.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, record review, and review of the facility policy, the facility failed to ensure residents' bathing areas were kept clean and homelike and failed to ensure ambient room temperatures were comfortable and at least 70 degrees Fahrenheit (F). This affected two residents (#2 and #45) and had the potential to affect all but six residents (#11, #19, #28, #41, #43, and #46) who were identified by the facility as residents who did not use the South or North shower rooms. The facility census was 54.</p> <p>Findings include:</p> <p>Record review for Resident #32 revealed an admission date of 12/11/23. Diagnosis included Alzheimer's disease, Parkinsonism, muscle weakness and need for assistants with care.</p> <p>Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #32 was severely cognitively impaired. Resident #42 was dependent for bathing/showering.</p> <p>Interview on 05/13/25 at 9:00 A.M. with Resident #32's wife revealed she assisted with showering Resident #32 routinely. Resident #32's wife revealed she was very concerned, both shower rooms were very dirty, (there were only two shower rooms shared by residents residing in the facility) odorous, and had broken parts that she had spoken to several staff members multiple times, and felt nothing had changed or been addressed.</p> <p>Observation on 05/13/25 at 9:41 A.M. of the North shower room with Licensed Practical Nurse (LPN) #549 revealed the shower room had a strong foul, musty odor, floor bases were corroded with a dark scummy substance surrounding the entire room. There were multiple broken tiles in the shower stall, and the edging in the three stalls were corroded. There was a soiled, wet washcloth lying on the floor and a pillow was lying on the floor next to the soiled toilet. Trash was on the floor including a used glove. Near the sink were several broken floor tiles, the ramp to the middle shower was embedded with dirt and scum and had broken pieces of material on both sides. The first shower stall had standing water on the floor with a brown/green ring surrounding a puddle of water. There was a shower bed against the wall with a brown smear in the center of the bed. LPN #549 verified the findings at the time of the observation.</p> <p>Observation on 05/13/25 at 9:48 A.M. of the South shower room with LPN #549 confirmed there was a strong musty odor and broken floor tiles broken and cracked along the base. There were three showers and two toilets. One toilet was broken, the second toilet was soiled with a dirty ring in the bowl with splattered fecal matter present. There were broken tiles, the ramp to the third shower was embedded with dirt. Paint was peeling and chipping off the ceiling. Grip tape was peeling off the grab bars in all three shower stalls, and floor strips were dirty and peeling. LPN #549 verified the findings at the time of the observation and stated many staff members complained about the state of the shower room, but the North and South shower rooms were the only two options for residents to shower.</p> <p>Observation of the North and South Shower rooms with DON on 05/14/25 at 12:26 P.M. also confirmed the vent on the ceiling in the South shower room was corroded and contained dust and scum build up. The DON confirmed the foul odor and revealed it was probably from the broken toilet. The DON confirmed both shower rooms were cleaned from the previous surveyor observations on 05/13/25 and confirmed both shower rooms remained odorous and contained multiple broken tiles and parts.</p>		

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<p>F 0585</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on record review and interview, the facility failed to establish a grievance committee consisting of no more than one staff for every two residents or representatives. This had the potential to affect all 54 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the facility's grievance committee members revealed it was comprised of two staff and two residents.</p> <p>On 05/13/25 at 10:06 A.M., an interview with the Administrator verified the grievance committee was comprised of two staff and two residents.</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>Based on closed medical record review, review of a facility self-reported incident (SRI), review of facility policy, and interview the facility failed to ensure Resident #52 was free from physical restraints.</p> <p>Actual Harm occurred on 03/08/25 at approximately 7:00 A.M. when Resident #52 was physically restrained and tied to his wheelchair with a bed sheet by Licensed Practical Nurse (LPN) #526 in an attempt to address Resident #52's behaviors and to prevent Resident #52 from standing from the chair. Resident #52 was found by visiting Hospice LPN #603 tied to his wheelchair with a bed sheet knotted behind him. The resident was unattended, seated in his wheelchair, agitated, and reported a pain rating of a 10 on a one-to-ten scale (with ten indicating the worst possible pain). Other interventions in place and available at the time of the incident, including as-needed (PRN) medications for pain, anxiety, and agitation, were not utilized by the nurse prior to Resident #52 being restrained. Hospice LPN #603 released Resident #52's restraint and hospice staff stayed one-on-one with the resident until his transfer out of the facility. This affected one resident (#52) of one resident reviewed for restraints. The facility census was 52.</p> <p>Findings include:</p> <p>Review of the closed medical record for Resident #52 revealed an admission date of 02/27/25. Medical diagnoses included congestive heart failure (CHF), anxiety disorder, and obstructive and reflux uropathy. Resident #52 received hospice services with Hospice #600 since his admission to the facility. Resident #52 discharged from the facility on 03/09/25.</p> <p>Review of Resident #52's physician orders revealed an order dated 02/27/25 to call Hospice #600 with any changes or concerns. Resident #52 had an additional order dated 02/27/25 for Oxycodone HCL (a narcotic pain reliever used to treat moderate to severe pain) 10 milligrams (mg) by mouth every two hours as needed (PRN) for pain.</p> <p>Review of the admission note dated 02/27/25 at 5:10 P.M. completed by LPN #526 revealed Resident #52 was alert and oriented to person, place, and time. Resident #52 communicated verbally, his speech was clear, and he was able to understand and be understood when speaking. Resident #52's mood was pleasant, and he had no unwanted behaviors. The resident had an indwelling catheter in place due to urinary retention. Resident #52's skin was warm and dry, his skin color was within normal limits, and skin turgor was normal. The note indicated Resident #52 sleeps through the night.</p> <p>Review of the Fall Risk evaluation dated 02/27/25 at 5:36 P.M., completed by LPN #526, revealed Resident #52 had one to two prior falls in the last three months. Resident #52 was noted to be ambulatory and continent. His fall risk score was 2.0</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the care plan dated 02/28/25 revealed Resident #52 was at risk for episodes of anxiety related to altered breathing and a terminal diagnosis. Listed interventions included addressing reasons for anxiety, social withdrawal, and crying, administering medications as ordered, monitor for medication side effects and effectiveness, and providing a quiet room or area for Resident #52 to go to when anxiety increases. Additional interventions included providing relaxation techniques as needed, removing excess stimulation as able, spending time talking with the resident, and allowing the resident to express their feelings.</p> <p>Further review of Resident #52's care plan dated 02/28/25 revealed the resident was at potential risk for falls related to age, decreased physical function, history of falls, and medication use. Listed interventions included to assist with transfers as needed, and an additional intervention added on 03/08/25 noted Resident #52 was to be one-on-one with hospice staff until transferred to an inpatient hospice facility.</p> <p>Further review of the care plan dated 02/28/25 and revised on 03/14/25 (after the resident's discharge) revealed Resident #52 had the potential for mood and behavioral issues related to depression, anxiety, terminal diagnosis, and insomnia. Resident #52 was combative with care, called emergency services at times, screamed out frequently, and had hallucinations. Listed interventions included administering medications as ordered, observing medication effectiveness and adverse reactions, attempting to provide a calm environment during acute phases, and approaching the resident in a calm and soothing manner. Additional interventions noted if the resident was demonstrating socially inappropriate behaviors, attempting to redirect the behavior. If the resident was unable to redirect, remove the resident from a public area. If the resident is resistive to care, leave the resident and return later if safety was not a concern.</p> <p>Review of the progress note for Resident #52 dated 02/28/25 at 8:47 A.M. completed by Assistant Director of Nursing (ADON) #519 included Resident #52 was pleasant and cooperative during assessment. Resident #52 denied urination since Foley (indwelling urinary catheter) was removed. The note indicated the resident was educated the Foley may need replaced if he was unable to void. Resident #52 verbalized understanding.</p> <p>Review of the Skilled Evaluation dated 02/28/25 at 7:17 P.M. completed by LPN #549 revealed Resident #52 followed commands. Resident #52 denied weakness, tremors, numbness or tingling. He was alert and oriented to person, place and time. Resident #52 communicated verbally, his speech was clear, and he was able to understand and be understood when speaking. Resident #52's mood was pleasant and there were no unwanted behaviors witnessed. Resident #52's urinary catheter was noted to be intact.</p> <p>Review of a nursing note dated 03/01/25 at 6:46 P.M. revealed Resident #52 was seated on his buttocks with his legs extended into the hallway. The resident reported he slid down the door frame and sat on the floor. Resident #52 had denied injury but was yelling at staff to call the police. Resident #52 was noted to be very combative with staff while he was being assessed.</p> <p>Review of the Skilled Evaluation dated 03/02/25 at 3:31 P.M. completed by LPN #509 revealed Resident #52 followed commands. Resident #52 denied weakness, tremors, numbness or tingling. He was alert and oriented to person, place and time. Resident #52 communicated verbally, his speech was clear, and he was able to understand and be understood when speaking. Resident #52's mood was pleasant and there were no unwanted behaviors witnessed.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of Resident #52's physician's orders revealed an order dated 03/02/25 at 4:15 P.M. for Ativan (an anxiolytic medication used to decrease anxiety) one mg every two hours as needed for anxiety.</p> <p>Review of the Brief Interview for Mental Status (BIMS) evaluation completed on 03/04/25 at 12:29 P.M. revealed Social Worker (SW) #529 completed the evaluation. Resident #52 was recorded to have a BIMS score of 13, indicating the resident was cognitively intact.</p> <p>Review of a nursing note dated 03/07/25 at 5:50 P.M. authored by LPN #526 revealed Resident #52 was very combative. The note referenced the resident's behaviors began around 8:00 A.M. with the resident hitting, biting, and pulling on his indwelling urinary catheter. Blood was noted in the urinary drainage bag. Resident #52's hospice provider, Hospice #600, was notified and medication changes were made. Resident #52 was given Haldol (an antipsychotic medication) by intramuscular route. The note referenced Resident #52 calmed down for 20 to 30 minutes. Resident #52 was noted to be very paranoid and hallucinating.</p> <p>Review of Resident #52's physician's orders revealed an order dated 03/07/25 at 1:45 P.M. for Haldol Lactate (Immediate release) injection five mg by intramuscular route, one-time only.</p> <p>Record review of the Medication Administration Record (MAR) revealed the one-time dose of Haldol Lactate was administered at on 03/07/25 4:27 P.M.</p> <p>Review of Resident #52's additional physician's orders revealed an order dated 03/07/25 at 7:15 P.M. for Haldol Lactate injection five mg by intramuscular route every six hours as needed for agitation.</p> <p>Review of Resident #52's MAR for March 2025 revealed the Haldol order (from 03/07/25 at 7:15 P.M.) was to be used as needed and was never recorded as administered.</p> <p>Review of a nursing note dated 03/08/25 at 1:35 A.M. authored by LPN #538 revealed Resident #52 was seen by an (unnamed) visiting hospice nurse and new orders were received for Haldol and Ativan due to agitation. Resident #52 was very restless and was tugging at his Foley catheter all night. The note stated Resident #52 was unable to be redirected. Resident #52 was transferring himself to the wheelchair without assistance, was wandering up and down the hallways, and was in and out of other residents' rooms. Resident #52 was difficult to redirect. Resident #52 was recorded as having been medicated with new orders without effectiveness. Resident #52 pulled his Foley catheter out with the balloon inflated and refused to allow the nurse to reinsert the catheter.</p> <p>Review of a nursing note dated 03/08/25 at 7:00 A.M. authored by Registered Nurse (RN) #550 revealed Resident #52 was propelling his wheelchair in the hallway. When Resident #52 reached the treatment cart, he held onto it and attempted to stand unassisted. Resident #52 lost his balance and fell with his right side against the wall before staff could reach him. He then slid down to the floor. Resident #52 denied any pain or discomfort following the incident.</p> <p>(continued on next page)</p>		

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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)		
<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Self-Reported Incident (SRI) tracking number 257988 dated 03/08/25 at 12:44 P.M. revealed the SRI report was created by Regional Director of Clinical Services (RDCS) #557 and completed on 03/11/25 at 5:48 P.M. The SRI reported an allegation/suspicion of neglect or mistreatment abuse by LPN #526. The brief description noted on 03/08/25 at 7:00 A.M., in an attempt to prevent Resident #52 from standing unassisted or falling out of his wheelchair, an employee placed a sheet over his lap and secured it behind the back of the wheelchair by tying it. The sheet was untied, and the resident was assessed for injury. There were no injuries found. The employee, LPN #526, was suspended immediately. The report noted the allegation was investigated by the facility and unsubstantiated, noting the evidence indicated abuse, neglect, or misappropriation did not occur.</p> <p>Review of a witness statement dated 03/08/25 at 7:00 A.M. authored by Housekeeping/Laundry Staff #501 revealed she was coming down the hall and Resident #52 went to get up and fell. The statement noted the nurse tried to catch him, but the resident went down. Resident #52 would not stay in the chair, so the nurse tried to keep him in the chair. The statement sated the nurse did what she needed to do to protect him, she did nothing wrong. At least she tried to protect him.</p> <p>Review of a witness statement dated 03/08/25 at 7:00 A.M. completed by LPN #526 revealed Resident #52 was up walking without a device, grabbing the medication cart. RN #550 tried to get to the patient before he fell. Resident #52's fall was witnessed; the resident did not hit his head or back but fell onto his buttocks to the floor. Resident #52 was put back into his wheelchair and became combative. Resident #52 was trying to get at staff and residents in the hallway. Resident #52 was put at nurse's station. This nurse applied a sheet around the resident's waist, loosely tied behind his back for his safety and other residents. Sheet loose enough he could pull and get out.</p> <p>Review of a witness statement dated 03/08/25 at 7:00 A.M. completed by Certified Nursing Assistant (CNA) #503 revealed Resident #52 was being combative and stood up from his wheelchair and grabbed onto the medication treatment cart and fell while pushing it. Resident #52 was very combative, so the nurse got a sheet and loosely put it around the resident's waist. He was going to hurt himself or others who were in the hallway, so it was tied loosely so he would not go face-first. Resident #52 had been combative since yesterday 03/07/25. The note referenced an unnamed hospice nurse was at the nurse's station with Resident #52. Resident #52 was eating snacks, she (unnamed hospice nurse) was standing beside him doing charting, and she was there for at least 45 minutes.</p> <p>Review of Resident #52's physician's orders revealed an order dated 03/08/25 at 9:00 A.M. for Oxycodone HCL five mg by mouth, a one-time dose, for agitation.</p> <p>Review of Resident #52's MAR for March 2025 revealed the one-time dose of Oxycodone was recorded as administered on 03/08/25 at 9:00 A.M. for a pain level of 10 on a one-to-ten scale, indicating the worst possible pain. The MAR listed the medication had been effective. Further review of Resident #52's MAR revealed the resident received one as-needed dose of Oxycodone on 03/08/25 at 8:59 P.M. Resident #52 additionally received as-needed doses of Ativan on 03/08/25 at 3:19 P.M. and 8:58 P.M., both of which were recorded as effective. There were no additional as needed medications recorded as administered on 03/08/25.</p> <p>(continued on next page)</p>		

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F 0604 Level of Harm - Actual harm Residents Affected - Few	<p>Review of a nursing note dated 03/08/25 at 10:46 A.M. authored by LPN #526 revealed Resident #52 was combative in the morning. Resident #52 was kept at the nurse's station for safety. The resident was attempting to hit the staff and trying to hit other residents. Resident #52 had grabbed a hold of a cart and was trying to stand up, almost pulling the cart onto himself and causing himself to fall. Staff were unable to catch the patient before the resident fell. The note referenced staff had tried to redirect the resident with coffee and a snack without success. Resident #52's hospice provider had been called and came for a visit. New orders were obtained. Hospice was performing one-on-one with the resident. Resident #52 was noted to be agitated.</p> <p>Review of Resident #52's physician's orders revealed an order dated 03/08/25 at 11:15 A.M. for Phenobarbital 60 mg, give one tablet by mouth every six hours as needed for agitation/restlessness.</p> <p>Review of a health status note for Resident #52 dated 03/08/25 at 12:30 P.M. authored by ADON #519 revealed it had been reported the resident was sitting up in his wheelchair with a blanket around him, secured loosely behind his chair. Staff reported the resident was still able to move around and could have stood if he tried. ADON #519 and an unnamed hospice nurse assessed Resident #52 for injury. The note referenced there was no injury observed, with the exception of a soft lump to the resident's shoulder. Resident #52 was recorded to have no pain with palpation, and the area was not discolored. An x-ray examination was ordered. Resident #52 denied pain. The note concluded by referencing Resident #52 was resting in bed with hospice staff at the resident's bedside.</p> <p>Review of the progress notes for Resident #52 dated 03/08/25 at 11:57 P.M. authored by LPN #538 revealed Resident #52 was agitated and pulling at his Foley catheter again. PRN medications were referenced as given and effective for a short amount of time. The note concluded by referencing hospice staff remained at the resident's bedside throughout the night. A subsequent note dated 03/09/25 at 1:22 A.M. referenced Resident #52 remained restless and agitated. PRN medications were referenced as given and effective. Resident #52 remained resting in bed.</p> <p>Review of Resident #52's MAR for March 2025 revealed the resident received doses of as-needed Phenobarbital 60 mg on 03/08/25 at 12:42 P.M. and 8:58 P.M. and on 03/09/25 at 4:29 A.M. All three doses were recorded as effective.</p> <p>Review of the Orders Administration note dated 03/09/25 at 3:16 P.M. authored by RN #550 revealed Resident #52 discharged from the facility to an inpatient hospice facility.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of email correspondence dated 03/12/25 and timed 9:31 A.M., provided to the survey team on 05/14/25 at 5:16 P.M., revealed Hospice LPN #603 emailed her statement and summary of events from 03/08/25 to the DON. The written statement noted Hospice Nurse #603 entered the facility on 03/08/25 at 7:45 A.M. Upon entering the facility, LPN #526 was coming down the hall and stated to Hospice LPN #603 I am not going to lie, I have him in a wheelchair at the nurse's station with a sheet around him and he is tied to the wheelchair. Hospice LPN #603 immediately went to the nurse's station where the resident was observed tied with a sheet. Hospice LPN #603 untied the resident, and Resident #52 stated my belly hurts and pointed to his left lower quadrant of his abdomen. Hospice LPN #603 questioned LPN #526 as to what medications had been provided to Resident #52 and was told to look in the narcotic book. Hospice LPN# 603 noted no intramuscular, as-needed Haldol had been administered even though the order provided on 03/07/25 to be administered as-needed every six hours. Hospice LPN #603 noted there had been no calls to Hospice #600 throughout the night (03/07/25 into the morning of 03/08/25). Hospice LPN #603 requested a dose of Haldol IM be administered. LPN #526 prepared and administered the dose of medication. Resident #52 had no reaction to the injection and was not combative or aggressive. Resident #52 was able to answer short questions appropriately and had intermittent confusion. Hospice LPN# 603 notified the Hospice provider on 03/08/25 at 8:02 A.M. and obtained STAT, one-time doses of Oxycodone 10 mg and Ativan one mg. Hospice LPN #603 also obtained an order for crisis care (around the clock, one-on-one care by a hospice staff member). Hospice LPN #603 communicated the stat orders to LPN #526 and requested they be administered. Hospice LPN #603 stayed with Resident #52 and approximately 20 minutes later the STAT doses of medications were administered by LPN #526. Hospice LPN #603 then assisted Resident #52 to stand, walk to, and sit down in another wheelchair. She later assisted Resident #52 to his room for oxygen to be applied and for administration of a breathing treatment. Hospice LPN #603 remained at the resident's side.</p> <p>A telephone interview on 05/13/25 at 4:19 P.M. with Hospice RN Team Leader #602 revealed resident #52 was supposed to be a long-term resident of the facility. Another nurse, Hospice LPN #603, was the nurse who arrived at the facility on 03/08/25 and saw the resident tied up. Hospice RN Team Leader #602 referenced after the incident; crisis care was provided after that. Hospice LPN #603 talked to Hospice RN Team Leader #602 about what she saw. Hospice LPN #603 reported to her that when she arrived at the facility, she was greeted by LPN #526 as she entered the hallway Resident #52's room was on. LPN #526 stated she was not going to lie, that she had Resident #52 in a wheelchair at the nurse's station with a sheet around him, tied to the wheelchair. Hospice LPN #603 had stated she went immediately to the nurse's station, located Resident #52, and untied the patient. The sheet was tied around Resident #52's waist and tied behind his back in the wheelchair. The sheet was tied under the handlebars (between the armrests), and the resident was unable to release it. As the hospice nurse untied Resident #52, he fidgeted with the sheet and reported abdominal pain in his lower abdomen. Resident #52 was later transferred to an inpatient hospice facility and passed away on 03/13/25.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A telephone interview on 05/13/25 at 5:31 P.M. with Hospice LPN #603 revealed she received a phone call on 03/08/25 at 6:47 A.M. from the facility that Resident #52 was agitated and pulled his urinary catheter out. Hospice LPN# 603 confirmed she arrived at the facility on 03/08/25 at 7:45 A.m. When she walked into the facility, LPN #526 walked up the hall and stated to her I am not going to lie, I have him tied to the wheelchair at the nurse's station. Hospice LPN #603 revealed she immediately went to the nurse's station and found Resident #52 seated in the wheelchair at the nurse's station. A sheet was tied around his waist, tied in the back with a traditional knot and tucked in between the armrest so it had him against the chair. Hospice LPN #603 stated Resident #52 could not get up. There were no staff at the nurse's station, there were no staff nearby monitoring the resident. Resident #52 was observed attempting to pull at the sheet, trying to get it loose, but was unsuccessful. Hospice LPN# 603 untied the resident. Hospice LPN #603 was able to get her hand between the sheet and the resident's abdomen, but there was no way the resident could have stood on his own. Resident #52 was complaining of abdominal pain. Hospice LPN #603 further reported staff had stated the resident had been agitated all night, but no phone call had been made to Hospice #600 to request a visit or any intervention. Hospice LPN #603 phoned the hospice provider and obtained new medication orders for a STAT (immediate) dose of Oxycodone and Ativan. At 8:00 A.M., I also gave him Haldol to make him more comfortable. She assisted Resident #52 to his room to help him reposition. Resident #52 was terminally restless and agitated from heart failure with a reduced ejection fraction. Hospice LPN #603 stated Resident #52 was transitioning into dying, and terminal restlessness is common during this period. Hospice LPN #603 additionally obtained an order for crisis care, around the clock hospice care at the resident's bedside. Some of the facility nurses felt the resident was overmedicated and would not administer medications, even though Resident #52 continued to have terminal restlessness. Hospice LPN #603 noted if Resident #52 had been properly medicated, there would not have been a need to restrain the resident. Hospice LPN #603 stated there were multiple medications that were not used prior to the facility staff physically restraining the resident. Hospice LPN #603 stated she was shocked and livid when she saw Resident #52 tied up, her heart broke for the resident as it was so unnecessary when there were unattempted interventions available.</p> <p>Interview on 05/14/25 at 8:33 A.M. with CNA #503 confirmed she was the CNA working on 03/08/25. CNA #503 revealed she saw resident #52 up walking around and revealed before he fell, he had the medication cart and attempted to push it when he fell. Following the resident's fall, CNA #503 stated we put him in his wheelchair by the nurse's station, he was eating snacks, and was standing up by the snacks. LPN #526 asked CNA #503 to get her a sheet. She retrieved the sheet, gave it to LPN #526, and then proceeded to go assist another resident. When she came back from assisting another resident, she saw the sheet tied around resident #52's waist. CNA #503 stated her shift started at 6:00 A.M. She was unsure what time it was when LPN #526 tied up Resident #52. CNA #503 stated after the sheet was tied, Resident #52 was just sitting there. She estimated the hospice nurse arrived approximately an hour or two later and untied the resident when she arrived. After the hospice nurse arrived and untied the resident, she stayed with him.</p> <p>Interview on 05/14/25 at 8:53 A.M. with the Director of Nursing (DON) confirmed the incident with Resident #52 being restrained was on a weekend and confirmed it was a Saturday. The DON confirmed he was not at the facility working that day. The DON revealed nurses absolutely should not tie residents up and believed the sheet was loosely tied so it did not prevent him from standing. The DON stated the nurse involved had a clean record and he felt her intentions were for the best of the resident.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of LPN #526's personnel record on 05/14/25 at approximately 8:55 A.M. with the DON revealed a date of hire of 10/19/21. LPN #526 did not have an evaluation completed in 2025 or 2025, and there was no evidence the nurse had received behavioral training since being employed at the facility. The DON confirmed LPN #526 remained an active employee of the facility.</p> <p>A follow up phone interview on 05/14/25 at 11:06 A.M. with Hospice LPN #603 confirmed Resident #52 had been tied up using a traditional knot, there was no slip pull on the sheet which restrained Resident #52 to the wheelchair. Hospice LPN #603 stated the resident had been trying to stand while she was attempting to untie the resident but was unable to. She described the knot as having two ties, in a knot which could not be released. After she had found Resident #52 restrained, Hospice LPN #603 called Hospice #600's administration and Hospice RN Team Leader #602 who contacted the facility's management.</p> <p>A follow up phone interview on 05/14/25 at 3:37 P.M. with Hospice RN Team Leader #602 revealed she notified ADON #519 on 03/08/25 at 10:01 A.M. via phone of the incident with Resident #52 being physically restrained. She notified ADON #519 via phone as it was a weekend the facility reported there was no administration present in the facility at that time.</p> <p>Interviews on 05/14/25 at 5:16 P.M. and 05/15/25 at 11:57 A.M. with the DON and RDCS #557 confirmed LPN #526 had not received behavioral training during her employment with the facility. RDCS #557 additionally confirmed the hospice notes or statements, including the emailed statement, were not included in the facility's investigation into the incident with Resident #52. The DON revealed Hospice LPN #603's emailed statement was still in her email. The DON printed and provided the email to the survey team during the interview. RDCS #557 revealed she was unaware of all the information regarding the incident with the restraint. The DON and RDCS #557 confirmed the facility documented in the witness statements that they were aware the nurse tied up Resident #52 at 7:00 A.M. and no staff working at the facility notified facility administration of the event. The DON reported this was part of abuse training which had previously been provided to all staff. RDCS #557 additionally confirmed facility administration was notified of this incident on 03/08/25 at 10:03 A.M. by Hospice RN Team Leader #602. The facility initiated a SRI and began their investigation. The Administrator did not obtain Resident #52's hospice notes or interview the hospice staff, yet submitted the final SRI three days after the initial SRI. Hospice staff emailed a statement to the DON four days after the event, after the final SRI had been submitted. The facility did not wait to ensure a complete investigation was completed. RDCS #557 stated if she had known, the outcome of the SRI could have been different. RDCS #557 revealed she was unsure why the SRI was unsubstantiated.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Restraint Free Environment revised 06/01/24 revealed it is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. Definition Physical Restraint refers to any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but not limited to tucking in a sheet tightly so that the resident cannot get out of bed or fastening fabric or clothing so that the resident's freedom of movement is restricted. Using devices in conjunction with a chair, such as trays, tables, cushions, bars or belts that the resident cannot remove and prevents the resident from rising. Convenience refers to any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest. The resident has the right to be treated with respect and dignity, including the right to be free from any physical or chemical restraint imposed for the purpose of discipline or staff convenience and not required to treat the resident's medical symptoms. Physical restraints may be used in emergency care situations for brief periods to permit medically necessary treatment that has been ordered by a practitioner, unless the resident has previously made a valid refusal of the treatment in question. Falls do not constitute self-injurious behavior or a medical symptom that warrants the use of physical restraints. Before the resident is restrained, the facility will determine the presence of a specific medical symptom that would require the use of restraints and determine how the restraint would treat the medical symptom, the length of time the restraint is anticipated to be used to treat the medical symptom, who may apply the restraint and the time and frequency the restraint will be released. The type of direct monitoring and supervision that will be provided during the use of the restraint.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163484.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy, the facility failed to report an injury of unknown origin to the Ohio Department of Health (ODH) as required. This affected one resident (#47) of two residents reviewed for reporting abuse, neglect, misappropriation or injuries of unknown origin. The facility census was 54.</p> <p>Findings include:</p> <p>Record review for Resident #47 revealed an admission date of 01/21/25. On 03/26/25 Resident #47 was transferred to the Hospital #604 and readmitted on [DATE]. Diagnosis included severe protein caloric malnutrition, altered mental status, chronic obstructive pulmonary disease (COPD) and weakness.</p> <p>Review of Hospital #604's discharge record dated 04/04/25 completed by Physician #605 included Resident #47 was admitted to Hospital #604 on 03/27/25. Documentation included the wound to the left lateral back was healed.</p> <p>Review of the admission Progress note dated 04/05/25 at 12:57 A.M. completed by Licensed Practical Nurse (LPN) #538 revealed Resident #47 returned to the facility. Record review revealed there was no documentation of any skin concerns to Resident #47's back.</p> <p>Review of the facility re-entry Clinical admission Assessment for Resident #47 dated 04/05/25 untimed completed by LPN #538 revealed there were no concerns documented to Resident #47's back.</p> <p>Review of the Medicare five-day Minimum Data Set (MDS) dated [DATE] revealed Resident #47 was moderately cognitively impaired. Resident #47 required substantial/maximal assistants with upper and lower body dressing, partial/moderate assistance with personal hygiene, bed mobility, dependent for chair/bed-to-chair transfer. Resident #47 had no skin tears.</p> <p>Review of the Skin Grid Non-Pressure dated 04/22/25 at 11:10 A.M. completed by Assistant Director of Nursing (ADON) #519 revealed Resident #47 had a new skin tear acquired to the lower back measuring 7.0 centimeters (cm) in length by 15.0 cm in width by 0.1 cm in depth with a scant amount of drainage. Documentation included, During wound rounds noted to have new skin tear to mid back region. Area cleansed with normal saline, xeroform and dry clean dressing (DCD) applied. Further record review of Resident #47's medical record revealed no information was documented to how and when the skin tear occurred.</p> <p>Review of the ODH Certification and Licensure System (CALs) website confirmed there was no SRI completed for the injury of unknown origin to Resident #47's lower back.</p> <p>Interview on 05/19/25 at 10:30 A.M. with ADON #519 revealed she found the skin tear on Resident #47's lower back on 04/22/25 when she rolled him over. ADON #519 confirmed the skin tear was new and confirmed she did not know how or when it happened. ADON #519 revealed she obtained orders for the treatment of the wound but never investigated how or when the wound occurred.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, review of the Ohio Department of Health (ODH) Certification and Licensure System (CALs), and review of the facility policy, the facility failed to thoroughly investigate incidents of potential abuse for two residents (#47 and #52) of two residents reviewed for investigations of abuse, neglect, misappropriation, or injuries of unknown origin. The facility census was 54.</p> <p>Findings include:</p> <p>1. Record review for Resident #47 revealed an admission date of 01/21/25. On 03/26/25 Resident #47 was transferred to the Hospital #604 and readmitted on [DATE]. Diagnosis included severe protein calorie malnutrition, altered mental status, chronic obstructive pulmonary disease (COPD) and weakness.</p> <p>Review of Hospital #604's discharge record dated 04/04/25 completed by Physician #605 included Resident #47 was admitted to Hospital #604 on 03/27/25. Documentation included the wound to the left lateral back healed.</p> <p>Review of the admission Progress note dated 04/05/25 at 12:57 A.M. completed by Licensed Practical Nurse (LPN) #538 revealed Resident #47 returned to the facility. Record review revealed there was no documentation of any skin concerns to Resident #47's back.</p> <p>Review of the facility re-entry Clinical admission Assessment for Resident #47 dated 04/05/25 untimed completed by LPN #538 revealed there were no concerns documented to Resident #47's back.</p> <p>Review of the Minimum Data Set (MDS) Medicare five-day assessment dated [DATE] revealed Resident #47 was moderately cognitively impaired. Resident #47 required substantial/maximal assistants with upper and lower body dressing, partial/moderate assistants with personal hygiene, bed mobility, dependent for chair/bed to chair transfer. Resident #47 had no skin tears.</p> <p>Review of the Skin Grid Non-Pressure dated 04/22/25 at 11:10 A.M. completed by Assistant Director of Nursing (ADON) #519 revealed Resident #47 had a new skin tear acquired to the lower back measuring 7.0 centimeters (cm) in length by 15.0 cm in width by 0.1 cm in depth with a scant amount of drainage. Documentation included, During wound rounds noted to have new skin tear to mid back region. Area cleansed with normal saline, xeroform and dry clean dressing (DCD) applied. Further record review of Resident #47's medical record revealed no information was documented to how and when the skin tear occurred.</p> <p>Review of the ODH CALS website revealed no Self-Reported Incidents (SRI) was completed for the wound of unknown source to Resident #47's lower back.</p> <p>Interview on 05/19/25 at 10:30 A.M. with ADON #519 revealed she found the skin tear on Resident #47's lower back on 04/22/25 when she rolled him over. ADON #519 confirmed the skin tear was new and confirmed she did not know how or when it happened. ADON #519 revealed she obtained orders for the treatment of the wound but never investigated how or when the wound occurred.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/19/25 at 10:34 A.M. with the Administrator revealed if a resident had an injury of unknown origin, an investigation should be initiated immediately to find the cause of the injury, and a SRI should have been completed to report the injury of unknown origin.</p> <p>Interview and record review with Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) #557 on 05/19/25 at 1:01 P.M. confirmed Resident #47 had a new skin tear to the lower back documented on 04/22/25 at 11:10 A.M. RDCS #557 confirmed no SRI was completed for Resident #47's skin tear to the back. DON confirmed there was no investigation completed at any time to determine how the skin tear that measured 7.0 cm in length by 15.0 cm in width by 0.1 cm in depth occurred.</p> <p>2. Review of the closed medical record for Resident #52 revealed an admission date of 02/27/25 and a discharge date of 03/09/25. Diagnosis for Resident #52 included congestive heart failure (CHF), anxiety disorder, and obstructive and reflux uropathy.</p> <p>Review of the Minimum Data Assessment (MDS) discharge return not anticipated assessment dated [DATE] revealed Resident #52's short term memory was ok and the cognitive skills for decision making was severely impaired. Resident #52 received scheduled and as needed (PRN) pain medication and had a condition or chronic disease that may result in a life expectancy of less than six months.</p> <p>Review of the physician orders for Resident #52 initiated 02/27/25 included to call Hospice #600 with changes or concerns.</p> <p>Review of the nursing note for Resident #52 dated 03/08/25 at 10:46 A.M. completed by LPN #526 included Resident #52 had been combative that morning. Resident #52 was kept at the nurse's station for safety. The note referenced the resident had been hitting staff and trying to hit other residents. The resident grabbed ahold of the medication cart, attempted to stand, and almost pulled the cart on himself causing himself to fall. Staff were unable to catch the resident before falling. Staff had attempted to redirect the resident with coffee and a snack without success. Hospice was called and arrived for a visit. New orders obtained. Hospice doing one-on-one with the Resident #52 who was noted to be agitated.</p> <p>Review of the Health Status note for Resident #52 dated 03/08/25 at 12:30 P.M. completed by ADON #519 included it had been reported Resident #52 was seated up in his wheelchair with a blanket around him, secured loosely behind his chair. Staff reported Resident #52 was still able to move around and could have stood if he tried. ADON #519 and an unnamed hospice nurse assessed the resident for injury. No injury was observed with the exception of a soft lump on Resident #52's shoulder. The note referenced the resident had no pain with palpation and no discoloration. An x-ray examination was ordered. Resident denied pain and the note concluded by referencing the resident remained resting in bed with hospice staff at his bedside.</p> <p>Review of the Orders Administration note for Resident #52 dated 03/09/25 at 3:16 P.M. completed by RN #550 revealed Resident discharged to hospice inpatient center.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the SRI with tracking number 257988 dated 03/08/25 at 12:44 P.M. created by Regional Director of Clinical Services (RDCS) #557 and completed 03/11/25 at 5:48 P.M. completed by RDCS #557 revealed the alleged perpetrator was listed as LPN #526. The Resident/Victim was listed as Resident #52. The brief description of the allegation/suspicion revealed that in an attempt to prevent Resident #52 from standing unassisted or falling out of wheelchair, an employee placed a sheet over his lap and secured it behind the back of the wheelchair by tying it. The sheet was untied and Resident #52 was assessed for injury. There was no injury noted. LPN #526 was suspended immediately. The conclusion listed the SRI was unsubstantiated and evidence indicated abuse, neglect or misappropriation did not occur.</p> <p>Review of the facility investigation file revealed there was no information/witness statement obtained from Hospice LPN #603 or any other hospice staff regarding the incident involving Resident #52 on 03/08/25.</p> <p>Review of the Witness Statement located in the facility investigation file revealed a written statement dated 03/08/25 at 7:00 A.M. completed by LPN #526 included this nurse applied a sheet around waste loosely tied behind back for his safety and other residents. Sheet loose enough he could pull and get out. Sheet removed when staff was able when calm.</p> <p>Review of the Witness Statement located in the facility investigation file revealed a written statement dated 03/08/25 at 7:00 A.M. completed by Certified Nursing Assistant (CNA) #503 which included so nurse got sheet and loosely put around resident he his waste was going to hurt himself or others who were in the hallway.</p> <p>Phone interview on 05/13/25 at 5:31 P.M. with Hospice LPN #603 revealed she received a phone call at 6:47 A.M. from the facility that Resident #52 was agitated and pulled his catheter out. Hospice LPN #603 confirmed she arrived at the facility at 7:45 A.M. Hospice LPN #603 revealed when she walked in the facility, LPN #526 was walking up the hall. Hospice LPN #603 stated LPN #526 looked at her and stated I am not going to lie, I have him tied to the wheelchair at the nurses station. Hospice LPN #603 revealed she immediately went to the nurses station, where Resident #52 was seated in the wheelchair. The sheet was tied around his waist, secured in the back with a traditional knot, and tucked in between the armrest so it had him against the chair. LPN #526 confirmed Resident #52 could not get up and she did not see staff present at or near the nurse's station monitoring him. Hospice LPN #603 stated she untied Resident #52. Before she untied him, Resident #52 was pulling at the sheet trying to get it loose, and confirmed Resident #52 was unable to get the sheet loose. Hospice LPN #603 stated if he had been properly medicated, he would not have been a need to restrain him. The facility staff had had a whole additional (hospice) team to utilize, and there were as-needed medications available that were unused. Hospice LPN #603 stated she was shocked and livid when she saw Resident #52 tied up. She stated tying up the resident was so unnecessary when there were so many resources for him that were unused.</p> <p>Interview on 05/14/25 at 8:33 A.M. with CNA #503 confirmed she was the CNA working on 03/08/25. CNA #503 revealed LPN #526 asked CNA #503 to get her a sheet. CNA #503 then went to help another resident. CNA #503 revealed her shift had started that day at 6:00 A.M. but she did not recall what time LPN #526 tied up Resident #52. CNA #503 confirmed the hospice nurse arrived an hour or two later and untied Resident #52 when she arrived.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An additional phone interview on 05/14/25 at 11:06 A.M. with Hospice LPN #603 confirmed there was not a quick-release, slip-pull knot on the restraint. Resident #52 tried to stand when he was taking the knot out he was trying to stand and could not, it had two ties, it was a knot which could not be released.</p> <p>Interviews on 05/14/25 at 5:16 P.M. and 05/15/25 at 11:57 A.M. with the DON and RDCS #557 confirmed the hospice notes or statements, including the emailed statement, were not included in the facility's investigation into the incident with Resident #52 on 03/08/25. The DON revealed Hospice LPN #603's emailed statement was still in her email. The DON printed and provided the email to the survey team during the interview. RDCS #557 revealed she was unaware of all the information regarding the incident with the restraint. The DON and RDCS #557 confirmed the facility documented in the witness statements that they were aware the nurse tied up Resident #52 at 7:00 A.M. and no staff working at the facility notified facility administration of the event. The DON reported this was part of abuse training which had previously been provided to all staff. RDCS #557 additionally confirmed facility administration was notified of this incident on 03/08/25 at 10:03 A.M. by Hospice RN Team Leader #602. The facility initiated a SRI and began their investigation. The Administrator did not obtain Resident #52's hospice notes or interview the hospice staff, yet submitted the final SRI three days after the initial SRI. Hospice staff emailed a statement to the DON four days after the event, after the final SRI had been submitted. The facility did not wait to ensure a complete investigation was completed. RDCS #557 stated if she had known, the outcome of the SRI could have been different. RDCS #557 revealed she was unsure why the SRI was unsubstantiated.</p> <p>Review of the facility policy titled, Unexplained Injuries dated 01/01/20 revealed all unexplained injuries, including bruises, abrasions, and injuries of unknown source will be investigated.</p> <p>Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation of Resident Property undated revealed the investigation protocol included the person investigating the incident should generally take the following actions: Interview the resident, the accused, and all witnesses. Witnesses generally included anyone who witnessed or heard the incident; came in close contact with the resident the day of the incident; and employees who worked closely with the accused employee and or alleged victim the day of the incident.</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>Based on record review, interview, and review of facility policy, the facility failed to permit Resident #302 to return to the facility after a hospitalization. This affected one (#302) of four residents reviewed for discharge. The facility census was 54.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #302 revealed an admission date of 12/21/24 with diagnoses including chronic obstructive pulmonary disease, lung cancer, opioid dependence, anxiety disorder, hypertension, depression, and encounter following alleged adult physical abuse.</p> <p>Review of the 30-day discharge notice, issued 01/07/25, revealed Resident #302 received the notice due to failure to comply with facility rules and behavior contract. The planned discharge location on the notice was listed as Haven of Rest in Akron (a homeless shelter). Resident #302 did not discharge at the end of the time period stated in the notice and remained in the facility.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment, dated 03/25/25, revealed Resident #302 had intact cognition (Brief Interview for Mental Status (BIMS) score of 13) and verbal behaviors toward others one-to-three days with an overall presence of behavioral symptoms.</p> <p>Review of the physician's assistant progress note, dated 04/21/25, revealed multiple calls were received over the weekend regarding Resident #302's behaviors, including threatening other residents and staff. The police were called twice for Resident #302. The resident was informed that a drug screen would be completed via blood draw and that his medications would be reduced. Resident #302 had rapid and repeating thoughts during conversation. The nursing staff reported Resident #302 had not been sleeping and had been displaying manic behaviors. Resident #302 declined a psychiatric consult at that time. Resident #302 was informed that he could not threaten those around him and further action would be taken if symptoms continued.</p> <p>Review of the progress note dated 04/22/25 at 11:40 A.M. revealed Resident #302 had been very manic that morning, yelling and cursing at staff, traveling at a high speed in his wheelchair throughout the facility, threatening to send staff to jail, had possession of beer, and the physician ordered to send Resident #302 to the hospital for a psychiatric evaluation. Emergency services were called and Resident #302 had to be physically picked up by three police officers and placed on the transport cot. Resident #302 left the facility at approximately 11:15 A.M.</p> <p>There were no progress notes indicating there were any attempts made to have Resident #302 return to the facility after 04/22/25.</p> <p>On 05/19/25 at 8:34 A.M., an interview with Social Services Designee (SSD) #529 confirmed Resident #302 was transferred out of the facility for a psychiatric evaluation and was not permitted to return, which was a decision made by the higher powers at the facility. SSD #529 stated she was aware the facility was required to allow Resident #302 to return.</p> <p>(continued on next page)</p>		

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<p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/19/25 at 8:42 A.M., an interview with SSD #529 stated Resident #302 went to a homeless shelter after being discharged from the hospital and the facility delivered his belongings and wheelchair to the homeless shelter afterward.</p> <p>On 05/19/25 at 10:11 A.M., an interview with the Director of Nursing (DON) stated Resident #302 had displayed behaviors toward other residents and staff, was using alcohol and marijuana, and had been issued a previous 30-day discharge notice. The DON said after the 30-day discharge was issued, the Long-Term Care Ombudsman informed the facility that the plan to discharge Resident #302 to a homeless shelter was not a safe discharge. The DON said Resident #302 was ultimately sent to the hospital for a psychiatric evaluation due to his continued behaviors, unwillingness to listen to staff, and unwillingness to follow the facility's rules. The DON confirmed Resident #302 did not return to the facility after the hospitalization and was discharged from the hospital to a homeless shelter.</p> <p>Review of the facility's policy titled Transfer and Discharge (including against medical advice (AMA), dated 02/05/25, indicated residents had the right to remain at the facility unless their transfer or discharge met one of the specified exemptions, which included the resident's welfare and needs could not be met by the facility, the safety of individuals in the facility were endangered due to the clinical or behavioral status of the resident, and/or the health of individuals in the facility would otherwise be endangered. The policy also included that if a resident was transferred from the facility to an acute care setting, the resident would be permitted to return to the facility upon discharge from the acute care setting.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165156.</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and review of facility policy, the facility failed to issue a discharge notice to Resident #302 prior to discharge. This affected one (#302) of four residents reviewed for discharge. The facility census was 54.</p> <p>Findings include:</p> <p>Review of the medical record for Resident #302 revealed an admission date of 12/21/24 with diagnoses including chronic obstructive pulmonary disease, lung cancer, opioid dependence, anxiety disorder, hypertension, depression, and encounter following alleged adult physical abuse.</p> <p>Review of the 30-day discharge notice, issued 01/07/25, revealed Resident #302 received the notice due to failure to comply with facility rules and behavior contract. The planned discharge location on the notice was listed as Homeless Shelter #900. Resident #302 did not discharge at the end of the time period stated in the notice and remained in the facility.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment, dated 03/25/25, revealed Resident #302 had intact cognition (Brief Interview for Mental Status (BIMS) score of 13) and verbal behaviors toward others one-to-three days with an overall presence of behavioral symptoms.</p> <p>Review of the physician's assistant progress note, dated 04/21/25, revealed multiple calls were received over the weekend regarding Resident #302's behaviors, including threatening other residents and staff. The police were called twice for Resident #302. The resident was informed that a drug screen would be completed via blood draw and that his medications would be reduced. Resident #302 had rapid and repeating thoughts during conversation. The nursing staff reported Resident #302 had not been sleeping and had been displaying manic behaviors. Resident #302 declined a psychiatric consult at that time. Resident #302 was informed that he could not threaten those around him and further action would be taken if symptoms continued.</p> <p>Review of the progress note dated 04/22/25 at 11:40 A.M. revealed Resident #302 had been very manic that morning, yelling and cursing at staff, traveling at a high speed in his wheelchair throughout the facility, threatening to send staff to jail, had possession of beer, and the physician ordered to send Resident #302 to the hospital for a psychiatric evaluation. Emergency services were called and Resident #302 had to be physically picked up by three police officers and placed on the transport cot. Resident #302 left the facility at approximately 11:15 A.M.</p> <p>Review of the progress notes, assessments, and documents uploaded to the chart revealed there was no evidence of a discharge notice was provided to Resident #302 after the resident was transferred to the hospital on [DATE] and Resident #302 not permitted to return to the facility.</p> <p>On 05/19/25 at 1:48 P.M., an interview with the Director of Nursing (DON) confirmed Resident #302 should have received a discharge notice when he was not permitted to return to the facility from the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 05/19/25 at 2:00 P.M., an interview with Social Services Designee (SSD) #529 stated Resident #302 was provided a transfer notice at the time he was sent out for the psychiatric evaluation and verified there was no discharge notice provided at that time. On 05/19/25 at 2:07 P.M., SSD #529 confirmed there was no discharge notice provided to Resident #302 once the facility decided to discharge him and not permit him to return to the facility.</p> <p>Review of the facility's policy titled Transfer and Discharge (including against medical advice (AMA), dated 02/05/25, indicated a discharge notice would be provided to the resident and representative in a language and manner in which they could understand prior to the discharge.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00165156.</p>

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident, family, and staff interview, record review, and review of the facility policy, the facility failed to ensure the residents received activities to meet their needs and preferences. This affected one (Resident #47) of two residents reviewed for activities. The facility census was 54.</p> <p>Findings include:</p> <p>Record review for Resident #47 revealed an admission date of 01/21/25. Diagnoses included severe protein calorie malnutrition, altered mental status, chronic obstructive pulmonary disease (COPD) and weakness.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was moderately cognitively impaired. Resident #47 felt it was somewhat important to listen to music, pets, keeping up with the news, and going outside to get fresh air.</p> <p>Review of the care plan for Resident #47 dated 01/24/25 revealed Resident #47 needed encouragement to participate in activities of interest. Resident #47 preferred independent activities in room. Interventions included to give resident verbal reminders of activity before commencement of activity. Turn on television and music in room to provide sensory stimulation.</p> <p>Review of the Building Relationships Resident and Family Interview Questions for Resident #47 undated provided by Activity Director #515 revealed Resident #47 was in the Army, enjoyed hunting, country music, trivia and exercise.</p> <p>Review of the Activity Calendar for March 2025 revealed no activities were provided past 2:00 P.M.; The Activity Calendar for April 2025 revealed activities included a 6:00 P.M. evening film scheduled on Mondays, Tuesdays, Wednesdays, and Thursdays. No activities were scheduled between 2:00 P.M. and 6:00 P.M. and no activities were scheduled after 6:00 P.M.; Review of the Activity Schedule for May 2025 revealed the 6:00 P.M. evening film was scheduled two days a week, Wednesdays and Fridays. No activities were scheduled between 1:00 P.M. and 6:00 P.M. Monday through Friday and no activities were scheduled after 2:00 P.M. on Saturday or Sunday.</p> <p>Interview on 05/12/25 at 11:02 A.M. with Resident #47's family member revealed, He is so tired of just lying in bed, he gets bored, then he falls, he is sick and tired of just looking at walls, he would like to get out of the room; I told the nurse please get him out room, activities don't do anything with him.</p> <p>Multiple observations of Resident #47 on 05/12/25, 05/13/25, 05/14/25, and 05/15/25 revealed Resident #47 never got out of bed or participated in activities.</p> <p>Interview on 05/19/25 at 8:45 A.M. with Resident #47 revealed sometimes he would like to get out of bed more, look outside and go outside when its warmer. Resident #47 confirmed he liked music and use to enjoy trivia but now usually stays in his room and denied having activities provided by staff.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/19/25 at 8:58 A.M. with Activity Director (AD) #515 revealed she provided activities for residents in person Monday through Friday. AD #515 stated Resident #47 usually did not participate in group activities and she provided one on one (1:1) visits for residents who did not participate in group activities. AD #515 confirmed Resident #47 enjoyed country music, trivia and exercise. AD #515 stated she could put music in his room, she stated never asked him, and it was a good idea to offer him music in his room. AD #515 revealed Resident #47 also liked trivia and exercise according to the Building Relationships Resident and Family Interview Questions and confirmed she never offered him any trivia books, magazines, or exercises and stated But that is a good idea. AD #515 stated she was the only activity person for the residents, and there were no assistants in activities. She stated it was challenging but she does her best. AD #515 stated she worked at the facility Monday through Friday, and she sets stuff for activities on the weekends. The items she sets out for residents were self-initiated. Churches also come on the weekend and gather residents for services. AD #515 revealed all 6:00 P.M. evening films were resident self-initiated since her activities she provides were only done until 2:00 P.M AT #515 will set the movie up, then the residents were to go in at 6:00 P.M. and turn the movie on themselves. She worked some weekends as weekend manager, four hours a day Saturday and Sunday, usually one weekend a month or sometimes every other month. When she does that, she gets a day off during the week. When she has off during the week and on most weekends, all activities except church were self-initiated which she confirmed Resident #47 was unable to do. AD #515 revealed on 10/20/24 she became AD and confirmed she was not certified to be an AD. AD #515 confirmed she visited 1:1 with Resident #47 two to three times a month reiterating she was the only activities person for all the residents.</p> <p>Interview on 05/19/25 at 9:38 A.M. with the Administrator stated all residents should have evening and weekends activities offered that were provided by staff, not just resident-initiated.</p> <p>Interview on 05/19/25 at 10:49 A.M. with Corporate Director of Life Enrichment and Memory Care #559 revealed it was the expectation that two evenings a week were staff driven or have staff there in the case of a music program and weekend activities.</p> <p>Review of the facility policy titled Activities dated 06/01/24 revealed it is the policy of the facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan and preferences.</p>		

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<p>F 0680</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure the activities program is directed by a qualified professional.</p> <p>Based on personnel record review and staff interview, the facility failed to ensure the Activities Director was qualified for the position. This had the potential to affect 54 of 54 residents. The facility census was 54.</p> <p>Findings include:</p> <p>Review of the personnel file for Activities Director (AD) #515 revealed no evidence of experience or certification to be an Activities Director. AD #515's file did not contain a signed job description.</p> <p>An interview on 05/19/25 at 8:58 A.M. with AD #515 revealed she was the only person in the activity department. She stated she was hired on 10/20/24 as Activity Director but was not certified.</p> <p>An interview on 5/19/25 at 9:23 A.M. with Human Resource Manager (HR) #535 verified AD #515 did not have any experience in activities according to her application and no signed job description for Activity Director.</p> <p>An interview on 05/19/25 at 9:38 A.M. with the Administrator revealed the Activity Director should be certified. The Administrator stated he was aware and never got around to addressing it.</p> <p>An interview on 05/19/25 at 10:49 A.M. with Corporate Director of Life Enrichment and Memory Care #559 revealed the facility hired the Activity Director for the facility. She trains staff on dementia and the expectations of the Activity Department. She goes over the one-on-one binder that the company expects to have at each facility. It is the expectation that two evenings a week are staff driven or have staff there in the case of a music program and weekend activities.</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interview, record review, and review of the facility policy, the facility failed to ensure safety measures and interventions were implemented to prevent potential accidents and hazards.</p> <p>Actual Harm occurred to Resident #21 on 02/01/25 when the facility failed to ensure Resident #21's smoking apron was in place during smoking and Resident #21 sustained a burn from his cigarette dropping on his right thigh. The burn had full thickness tissue loss with 100 percent (%) slough (dead tissue) in the wound bed, and required debridement. This affected three residents (#21, #28 and #47) and had the potential to affect an additional five additional residents, Residents #3, #33, #40, #42, and #303 who were identified by the facility as being independently mobile, cognitively impaired and able to reach the unsecured box with cigarettes and lighters. The facility census was 54.</p> <p>Findings include:</p> <p>1. Record review for Resident #21 revealed a readmission date of 07/23/23 with diagnoses including dementia, anxiety disorder, and Alzheimer's disease.</p> <p>Review of the care plan dated 03/25/21 revealed Resident #21 had impaired cognitive process for daily decision making. Resident #21 was at risk for further decline in cognitive status. Interventions included to anticipate needs and keep resident clean, dry and comfortable every shift and provide a stable and supportive environment through consistencies in daily routine as able.</p> <p>Resident #21 also had a care plan related to a potential for safety hazard or injury related to smoking. The care plan revealed Resident #21 was able to smoke with supervision by staff or family. Smoking apron would be provided to Resident #21 during smoking times, effective 12/08/20. The care plan also revealed smoking materials were to be returned to nurse's station after smoke break and while smoking, (resident) would have direct supervision by staff or family member.</p> <p>Review of the Smoking and Safety assessment for Resident #21 dated 12/09/24 completed by Licensed Practical Nurse (LPN) #526 revealed Resident #21 used tobacco, had limited or no range of motion in arms and hands, insufficient fine motor skills needed to securely hold tobacco, marijuana or vape products, and drops ashes on self.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #21 was moderately cognitively impaired. Resident #21 used a wheelchair for mobility, was independent for eating and wheelchair mobility, and was dependent on staff for oral hygiene, upper and lower body dressing, and transfers.</p> <p>Review of the progress note for Resident #21 dated 02/01/25 completed by LPN #549 revealed found cigarette burn on right thigh, and the area was cleaned with normal saline (NS), Xeroform and bordered foam dressing applied. The progress note revealed education was given to wear smoking apron at smoke breaks.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Incident Report (IR) for Resident #21 dated 02/01/25 completed by LPN #549 revealed found burn mark on resident's right thigh. Resident description I dropped my cigarette on my lap. The report revealed educated staff on smoking apron use. The IR included reviewed with interdisciplinary team (IDT) and agree with intervention plan of educating staff on need of wearing apron to smoke dated 02/05/25.</p> <p>Review of the skin grid for Resident #21 dated 02/04/25 at 11:04 A.M. completed by Assistant Director of Nursing (ADON) #519 revealed burn originated on 02/01/25, full thickness tissue loss with 100% slough (dead tissue) in the wound bed, Xeroform used for autolytic debridement.</p> <p>Observation on 05/15/25 at 1:52 P.M. of the North side where Resident #21 resided revealed a smoking box sitting on the counter at the nurse's station. The smoking box had a locking mechanism available on the box but was left unlocked. Observation revealed multiple packs of cigarettes and lighters in the box. Observation revealed no staff were in the vicinity as visitors and residents were nearby until 2:05 P.M.</p> <p>Observation on 05/15/25 at 2:05 P.M. revealed LPN #549 returned to the nurse's station. LPN #549 confirmed the smoking box was unlocked and unsecured and within reach of any residents passing by.</p> <p>The facility identified five additional residents, Resident #3, #33, #40, #42, and #303 who were independently mobile, cognitively impaired and able to reach the unsecured box with cigarettes and lighters creating a potential accident hazard for these residents.</p> <p>Interview on 05/15/25 at 3:27 PM with LPN #549 verified the burn on Resident #21's leg was from a cigarette burn. LPN #549 stated she educated the certified nursing assistants (CNA) to make sure the resident had his smoking apron. However, LPN #549 stated she did not put the education in writing, she just told them stating, They should know, he was always supposed to have one. LPN #549 revealed there were two CNAs that she in-serviced on that day but she could not remember who they were and confirmed she did not in service any other staff.</p> <p>Interview on 05/15/25 at 3:39 P.M. with Director of Nursing (DON) confirmed he was aware of Resident #21 burning his leg with a cigarette and confirmed the intervention was to in-service staff on the need for Resident #21 to wear a smoking apron when he smokes. The DON revealed the in-service was one that was placed at the nurse's station for staff to read and sign. The DON revealed he was unable to find the in-service and confirmed he was unsure if all the staff read and signed the in-service. The DON confirmed the box located at the nurse's station with resident's smoking supplies should be locked when not in use.</p> <p>Review of the facility policy titled Resident Smoking revised 01/16/25 revealed it was the policy of the facility to provide a safe and healthy environment for residents, visitors and employees, including safety as related to smoking. Smoking materials would be maintained by nursing staff. All safe smoking measures would be documented on each resident's care plan and communicated to all staff, visitors, and volunteers who would be responsible for supervising residents while smoking,</p> <p>2. Record review for Resident #47 revealed an admission date of 01/21/25. Diagnoses included severe protein calorie malnutrition, altered mental status, chronic obstructive pulmonary disease (COPD) and weakness.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #47's history of falls for the past 60 days revealed Resident #47 had a fall on 03/26/25, 04/10/25, and 04/26/25.</p> <p>Review of the care plan for Resident #47 dated 04/25/25 revealed Resident #47 was a potential risk for falls related to age, medication, confusion, restlessness, attempting to transfer without assist. Interventions included to ensure the call light was within reach at all times.</p> <p>Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was moderately cognitively impaired. Resident #47 was dependent on staff for bed mobility and transfers. Resident #47 had falls since admission.</p> <p>Observation on 05/12/25 at 7:01 A.M. revealed Resident #47 was lying in bed. The call light was located behind the head board at the head of the bed.</p> <p>Observation and interview on 05/12/25 at 7:07 A.M. with LPN #553 verified Resident #47's call light was behind the headboard and verified Resident #47 would not be able to reach the call light to use it.</p> <p>Observation and interview on 05/19/25 at 10:12 A.M. with LPN #509 verified Resident #47's call light was in the top drawer of the night stand with the door closed. Resident #47 confirmed he could not reach the call light. LPN #509 also confirmed Resident #47 could not reach the call light and verified Resident #47 would not have been able to place the call light in the nightstand drawer and close the drawer. LPN #509 stated his CNA #503 must have put it there and stated Resident #47 falls when he tries to get up unattended. Resident #47 does use the call light when he can reach it.</p> <p>Interview on 05/19/25 at 10:19 A.M. with CNA #503 stated she did not put Resident #47's call light in his night stand drawer and said night shift staff must have put in the drawer. CNA #503 confirmed Resident #47 understands how to use the call light.</p> <p>3. Review of the medical record for Resident #28 revealed an admission date of 01/29/24 with diagnoses including atrial fibrillation, cerebral infarction, mood affective disorder, major depressive disorder, hypertension, cognitive communication deficit, muscle weakness, anxiety disorder, and unsteadiness on feet.</p> <p>Review of the care plan, initiated 02/22/24, revealed Resident #28 had a potential risk for falls related to age, cognitive function, decreased physical function, history of falls, medications, transferring and ambulating without assistance, and buckling his knees at time while staff were providing assistance. Interventions included fall risk assessments to be completed on admission, quarterly, and as needed (initiated 02/22/24), ensure call light within reach (initiated 02/22/24), assist with transfers as needed (initiated 02/22/24), encourage use of assistive devices for transfers or ambulation (initiated 02/22/24), a call don't fall sign for a visual reminder to ask for assistance (initiated 04/17/24), medication review (initiated 11/30/24), and a dycem to recliner (initiated 03/07/25).</p> <p>Review of the fall risk evaluation, dated 01/15/25, revealed Resident #28 scored a three and the evaluation indicated a score of 10.0 or higher was considered high risk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress note dated 03/07/25 at 5:15 P.M. revealed Resident #28 slid to the floor from the chair and there were no visible injuries noted. Vital signs were within normal limits, Resident #28 refused to speak about the incident, and the resident was assisted back into the chair with call light within reach.</p> <p>Review of the fall investigation dated 03/07/25 revealed Resident #28 had an unwitnessed fall with no injury. Resident #28 was oriented to person only at the time of the fall. The new intervention was a dycem (non-skid pad) placed in the recliner to help reduce the chance of sliding.</p> <p>Review of the annual Minimum Data Set (MDS) assessment, dated 04/15/25, revealed Resident #28 had moderate cognitive impairment, required substantial/maximal assistance or total dependence for activities of daily living (ADLs), and had one fall without injury since the last assessment.</p> <p>On 05/12/25 at 9:56 A.M., an observation of Resident #28's room revealed there was no dycem in the recliner. Resident #28 was in his recliner and his call light was not within reach. Interview with Certified Nursing Assistant (CNA) #517 verified there was no dycem in the recliner and the call light was within reach of Resident #28. CNA #517 stated the call light was on the opposite side of bed.</p> <p>On 05/12/25 at 1:16 P.M., an observation of Resident #28's room revealed Resident #28 was in his recliner and there was still no dycem in the recliner. Interview at the time of observation with CNA #517 verified there was no dycem in the recliner.</p> <p>On 05/15/25 at 10:31 A.M., an interview with Licensed Practical Nurse (LPN) #549 confirmed Resident #28 had experienced falls. LPN #549 was unable to state what fall interventions were supposed to be in place for Resident #28 and when looking it up in the chart, LPN #549 only looked at physician's orders and stated there were no orders for any fall interventions. LPN #549 was unaware of where to locate the fall interventions in the chart for Resident #28.</p> <p>Review of the facility policy titled Fall Prevention and Management, dated 01/08/24, revealed residents would be assessed for fall risk on admission, quarterly, after a fall, and as needed. Individualized interventions would be implemented based on the assessment and risk factors, interventions would be monitored for effectiveness, and the plan of care would be revised as needed. In the event of a fall, an intervention aimed to prevent further falls would be implemented, the interdisciplinary team would review the fall and new interventions that were identified or implemented, and discuss any new interventions that may help prevent further falls.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00161001.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, record review, and review of the facility policy, the facility failed to ensure a resident had physician orders for oxygen therapy and to maintain the oxygen supplies. This affected one (Resident #47) of two residents reviewed for oxygen.</p> <p>Findings include:</p> <p>Record review for Resident #47 revealed an admission date of 01/21/25. Diagnoses included chronic obstructive pulmonary disease (COPD), adult failure to thrive and weakness.</p> <p>Review of the significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #47 was moderately cognitively impaired. Resident #47 was dependent with eating, dressing and personal hygiene. Resident #47 had shortness of breath or trouble breathing while lying flat. Resident #47 did not receive oxygen therapy.</p> <p>Review of the active physician orders for Resident #47 revealed there was no orders for Resident #47 to receive oxygen therapy. Resident #47 had an order dated 04/26/25 to admit to Hospice Services #606.</p> <p>Observation on 05/12/25 at 7:01 A.M. revealed Resident #47 was resting quietly in bed. An oxygen concentrator was sitting next to the bed and was running at four liters per minute. Resident #47 had a nasal cannula in his nostrils. The oxygen tubing was lying on the floor and not connected to the concentrator.</p> <p>Observation and interview on 05/12/25 at 7:08 A.M. with Licensed Practical Nurse (LPN) #553 confirmed the oxygen concentrator was sitting next to the bed and was running at four liters per minute, Resident #47 had a nasal cannula in his nostrils, and the oxygen tubing was lying on the floor and not connected to the concentrator. LPN #553 reconnected the tubing to the concentrator and stated she was not sure why it was disconnected or how long it was disconnected for.</p> <p>Interview on 05/12/25 at 8:41 A.M. with LPN #553 confirmed Resident #47 did not have an order for oxygen therapy and confirmed Resident #47 received continuous oxygen.</p> <p>Observation on 05/15/25 at 2:31 P.M. revealed Resident #47 was resting in bed quietly. Resident #47 had oxygen on via nasal cannula at four liters per minute.</p> <p>Observation and interview on 05/15/25 between 2:34 P.M. and 2:49 P.M. with LPN #549 verified Resident #47 was receiving oxygen at four liters per minute and confirmed the humidifier bottle on the concentrator was empty. Resident #47 revealed his nose felt, very dry and sore inside LPN #549 confirmed there was no physician order for Resident #47 to receive oxygen therapy.</p> <p>Interview on 05/15/25 at 2:56 P.M. with Director of Nursing (DON) revealed if a resident received oxygen therapy, they should have an order in the electronic medical record and a magnet on the outside of their door. The oxygen tubing would be changed weekly and as needed and staff would make sure the solution in the humidifying bottle did not run empty.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 05/19/25 at 8:31 A.M. with DON confirmed Resident #47 had been receiving oxygen therapy prior to Hospice initiating services and confirmed Resident #47 received the oxygen therapy without a physicians order.</p> <p>Review of the facility policy titled Oxygen Administration revised 01/04/23 revealed oxygen is administered under the orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable when the situation is under control.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.</p> <p>Based on record review, interview, and the facility submitted Payroll Based Journal (PBJ) tracking information, the facility failed to ensure a registered nurse (RN) was on duty for at least eight consecutive hours a day, seven days a week as required. This had the potential to affect all 54 residents residing in the facility.</p> <p>Findings include:</p> <p>Review of the PBJ Staffing Data Report form submitted from 07/01/24 through 09/30/24 revealed the following dates submitted for the third quarter of the fiscal year 2024, the facility was low on RN hours in the building on the seven following dates: 07/26/25, 07/31/25, 08/01/25, 08/05/25, 08/10/25, 08/11/25, and 08/28/25.</p> <p>Interview on 05/14/25 at 9:08 A.M. with the Administrator revealed he started in June 2024 and was told there was a concern with getting RNs hired. The Administrator stated they hired RNs and should be okay now.</p> <p>Review of the schedules and assignment sheets from 07/01/24 through 09/30/24 with Human Resource Manager (HR) #535 and the Administrator on 05/15/25 at 11:17 A.M. revealed a RN was present in the building for at least eight consecutive hours a day, seven days a week as required except for the following dates during the fourth quarter of the fiscal year 2024, the facility was low on RN hours in the building on the following dates: 08/10/25 and 08/11/25. Review of schedules, assignment sheets, time cards and census revealed the Director of Nursing (DON) who was an RN was present in the facility and the census was less than 60 residents for the following dates: 07/26/25, 07/31/25, 08/01/25, 08/05/25, and 08/28/25.</p> <p>The deficient practice was corrected when the facility implemented the following corrective actions which were implemented on 08/16/24:</p> <p>&bull;</p> <p>On 08/16/24, Scheduler #528, the Director of Nursing (DON), and the current Administrator were in-serviced by Former Administrator #600.</p> <p>&bull;</p> <p>On 08/16/24, the facility started daily meetings to ensure RN coverage. The attendees included Administrator, DON, Assistant DON #519, Human Resource Manager #535, and Scheduler #528. The daily meetings will look forward to staff needs so facility staff and staff in sister facilities can be offered extra hours, and/or agency if need be.</p> <p>&bull;</p> <p>(continued on next page)</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 08/16/24, the facility has implemented a RN on-call rotation.</p> <p>&bull;</p> <p>On 08/16/24, the facility offered a \$10,000 sign-on bonus for RNs. The facility has hired the following RNs and were still working in the facility: RN #550 was hired on 11/05/24 and RN #536 on 01/24/25. Licensed Practical Nurse (LPN) #511 was hired on 03/11/25 and was obtaining her RN degree which will be obtained in June 2025.</p> <p>&bull;</p> <p>Further review of PBJ reports, schedules and assignment sheets from 08/16/25 through 04/30/25 revealed a RN was present in the building for at least eight consecutive hours a day, seven days a week as required when the census was below 60 residents.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>Based on record review, resident and staff interviews, and observation of a test tray, the facility failed to serve foods at a palatable temperature. This had the potential to affect all 54 residents residing in the facility who receive food from the kitchen.</p> <p>Findings include:</p> <p>Review of the diet order listing report revealed there were no residents with orders for nothing by mouth (NPO) and all 54 residents had oral diet orders in place.</p> <p>On 05/12/25 at 8:13 A.M., an interview with Resident #36 stated the food was awful.</p> <p>On 05/12/25 at 10:31 A.M., an interview with Resident #25 stated the food was cold.</p> <p>On 05/12/25 at 11:40 A.M., an interview with Resident #153 stated the food was horrible.</p> <p>On 05/14/25 from 10:49 A.M. to 12:12 P.M., an observation of the tray line for lunch service and review of a test tray with Dietary Manager (DM) #525 revealed the following: at 11:52 A.M., the test tray was plated on the line; at 11:56 A.M., the test tray was put on the delivery cart and the delivery cart left the kitchen immediately after; at 11:57 A.M., the cart was delivered to the unit; from 11:59 A.M. to 12:12 P.M., nursing staff were observed passing resident lunch trays; at 12:12 P.M., the test tray was delivered to the nurse's station. The test tray temperatures were measured by DM #525 using the facility's thermometer. The creamed spinach was 116.2 degrees Fahrenheit (F) and felt lukewarm upon tasting, the pork chop was 116.4 degrees F and felt lukewarm upon tasting, the diced potatoes were 116.4 degrees F and felt lukewarm upon tasting. Interview at the time of observation with DM #525 verified the temperatures of the foods on the test tray and stated hot food should be a minimum 125 degrees F at the time of service.</p>		

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NAME OF PROVIDER OR SUPPLIER Autumnwood Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 275 East Sunset Drive Rittman, OH 44270	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on record review, interview, observations, review of chemical sanitizer directions for use, and review of dishwasher manufacturer's directions, the facility failed to properly sanitize dishware after washing, discard expired foods in a timely manner, and maintain food storage areas in a clean manner. This had the potential to affect all 54 residents residing at the facility who receive food from the kitchen.</p> <p>Findings include:</p> <p>Review of the diet order listing report revealed there were no residents with orders for nothing by mouth (NPO) and all 54 residents had oral diet orders in place.</p> <p>Review of an email dated 04/21/25 at 7:52 A.M., between the facility and the chemical company who maintains their dish machine, indicated the Administrator had spent a week to verify there was no lease on the dish machine and that the facility needed someone out as soon as possible to resolve the temperature issues. An email, dated 04/21/25 at 8:15 A.M. requested an expedited process because this has been a problem for a while. An email dated 04/21/25 at 9:36 A.M. requested someone come to the facility as soon as possible because the high temperature was out and the unit has been down for a while.</p> <p>On 05/12/25 from 6:55 A.M. to 7:22 A.M., the initial tour of the kitchen revealed the sanitizer solution concentration was tested using the Hydrion QT-40 test strips, which have the following indicators: no color change represents a concentration of zero parts per million (ppm), pale yellow represents a concentration of 150 ppm, light green represents a concentration of 200 ppm, bright green represents a concentration of 400 ppm, and dark green represents a concentration of 500 ppm. At the time of the initial tour of the kitchen, three separate test strips turned pale yellow which was indicative of a concentration of 150 ppm. At the time of observation, Dietary Manager (DM) #525 verified with a color match against the test strip packaging that the sanitizer solution concentration was 150 ppm. At no point during the initial tour was the sanitizer solution discarded or fresh sanitizer solution mixed.</p> <p>Review of an email dated 05/12/25 at 11:50 A.M., between the facility's corporate office and the dish machine repair contractor, indicated the problem with the dish machine has been on-going for a while now and the quote for repairs was approved.</p> <p>On 05/13/25 at 8:53 A.M., an interview with DM #525 stated the facility had been having issues with the dish machine for multiple weeks and the machine was not reaching the minimum temperature of 180 degrees Fahrenheit (F) necessary for proper sanitization. Observation at the time of interview of the dish machine being run with an electronic thermometer inside the machine revealed the maximum temperature reached was 160.7 degrees F. The thermometer temperature was verified by DM #525 at the time of observation. DM #525 stated dietary staff had been running dishware through the dish machine and then using a bucket of sanitizer solution afterward. DM #525 then demonstrated by dipping each dish in the sanitizer solution and immediately removing it from the solution, stacking the dishes to the side of the sanitizer and not leaving all dishes fully submerged in the solution.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 05/13/25 at 11:32 A.M., an interview with the Administrator verified the contents of multiple emails indicated the dish machine had not been working properly for a while.</p> <p>On 05/13/25 at 11:36 A.M., an observation of the south unit medication storage room revealed the snack storage area contained Jello with an expiration date of 02/20/25, applesauce with an expiration date of March 2025, excessive ice buildup in the mini fridge used for food storage, hair stuck to the shelf inside the fridge, and multiple spills inside the fridge. Interview at the time of observation with the Director of Nursing (DON) verified the fridge condition and the expired food items.</p> <p>On 05/13/25 at 11:53 A.M., an interview with the Administrator stated he was alerted to the problem with the dish machine about a week and a half prior to the first email sent. He further stated all communication prior to that email was via telephone and he had no documentation for those conversations. He also said he personally went to the kitchen to observe their process for sanitizing dishes. The Administrator verified DM #525 was not following the proper procedures for sanitizing the dishes because DM #525 was just dipping the dishes in the sanitizer solution, immediately taking them back out and then stacking them to the side of the sanitizer without leaving all dishes submerged for the proper amount of time.</p> <p>Review of the manufacturer's label for the sanitizer solution revealed it was an effective sanitizer at an active quaternary concentration of 200 ppm to 400 ppm. The label further indicated that items such as drinking glasses, dishes, and eating utensils should be fully immersed in the 200 ppm to 400 ppm solution for at least 60 seconds for sanitization.</p> <p>Review of the manufacturer's information for the dish machine revealed the machine was a high temperature machine and the final rinse temperature should be between 180 degrees F and 195 degrees F during the sanitizing rinse every cycle.</p>		

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<p>F 0838</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to thoroughly assess the needs of its resident population by accurately evaluating residents with diseases, conditions, and physical and behavioral health needs to determine what resources were necessary to care for its residents competently. This had the potential to affect 37 residents (Residents #1, #3, #4, #5, #6, #8, #9, #10, #11, #14, #18, #19, #20, #21, #23, #24, #25, #26, #28, #29, #30, #32, #34, #36, #37, #38, #39, #40, #42, #44, #45, #47, #48, #152, #153, #303, and #304) who resided in the facility at time of entrance and had a psychiatric and/or mood diagnosis.</p> <p>Findings include:</p> <p>Review of the facility assessment dated [DATE] revealed no residents were identified with psychiatric and/or mood disorder diagnoses. Staffing was identified as being adequate for caring for residents with dementia, mental health conditions, needed because behavioral health services or history of trauma as evidenced by the facility noted it was not applicable (N/A).</p> <p>Interview on 05/15/25 at 11:28 A.M. with the Administrator verified the facility assessment did not identify any residents with psychiatric and/or mood disorder diagnoses.</p> <p>Interview on 05/15/25 at 11:32 A.M. with Director of Nursing (DON) confirmed 37 residents (Residents #1, #3, #4, #5, #6, #8, #9, #10, #11, #14, #18, #19, #20, #21, #23, #24, #25, #26, #28, #29, #30, #32, #34, #36, #37, #38, #39, #40, #42, #44, #45, #47, #48, #152, #153, #303, and #304) who resided in the facility at time of entrance had a psychiatric and/or mood diagnosis.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, review of the Centers for Disease Control and Prevention (CDC) guidance, and review of the facility policy, the facility failed to ensure residents who had indwelling medical devices and/or wounds were on enhanced barrier precautions (EBP), ensure staff wore the appropriate personal protective equipment (PPE) for residents on EBP, and ensure staff followed proper hand hygiene when providing care to the residents. This affected three residents (Resident #5, #47, and #152). The facility census was 54.</p> <p>Findings include:</p> <p>1. Record review for Resident #47 revealed an admission date of 01/21/25. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 was moderately cognitively impaired and was dependent on staff for activities of daily living.</p> <p>Review of the physician orders for May 2025 revealed Resident #47 had a physician order dated 04/22/25 to change the peripherally inserted central catheter (PICC) dressing weekly every Tuesday. An additional order dated 04/17/25 revealed to flush the PICC line every shift for skin integrity.</p> <p>Review of the care plan dated 04/28/25 revealed Resident #47 had potential for complications related to use of intravenous (IV) medications and had a PICC line on right arm with single lumen. Interventions included EBP.</p> <p>Observation and interview on 05/12/25 at 11:38 A.M. with Licensed Practical Nurse (LPN) #553 revealed Resident #47 was lying in bed and had a PICC line in his right upper arm. LPN #553 stated she did not know Resident #47 had a PICC line. LPN #553 confirmed Resident #47 was not on EBP and confirmed there was no PPE outside or inside his doorway. LPN #553 confirmed the dressing covering the PICC line was loose at the bottom exposing the insertion site and the dressing had no date on it to verify the last time it was changed. LPN #553 returned to the medication cart, gathered equipment to flush the PICC line with then returned to Resident #47's room. LPN #553 put on disposable gloves, no gown, flushed Resident #47's PICC line with 10 milliliters (ml) of saline flush. LPN #553 then assessed Resident #47's colostomy and burped (opening the bag, letting the air out then re-closing the bag) the colostomy bag. LPN #553 then removed her gloves and exited the room without washing her hands. LPN #553 confirmed she did not wash her hands after removing her gloves and exiting Resident #47's room.</p> <p>Interview with Assistant Director of Nursing (ADON) #519 on 05/12/25 at 11:45 A.M. confirmed Resident #47 should be on EBP and confirmed there was no PPE available inside or outside Resident #47's room.</p> <p>2. Record review for Resident #5 revealed a re-admission date of 01/15/25. Review of the State Optional Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #5 was cognitively intact and required extensive assistance with bed mobility and toilet use and had one unhealed stage four (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer.</p> <p>Review of the care plan revised 04/16/25 revealed Resident #5 had an actual area of skin impairment related to a pressure ulcer to the mid back. Interventions included EBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation and interview on 05/14/25 at 12:41 P.M. of incontinence care for Resident #5 provided by Certified Nursing Assistant (CNA) #531 revealed CNA #531 did not wear an isolation gown while providing peri care for Resident #5. There was an isolation container outside Resident #5's doorway with appropriate PPE. CNA #531 confirmed she did not wear an isolation gown and confirmed she was required to wear an isolation gown while providing care for Resident #5. CNA #531 stated she forgot to put on a isolation gown.</p> <p>3. Record review for Resident #152 revealed a readmission date of 04/23/25. Review of the Medicare five-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #152 was moderately cognitively impaired and had diabetes mellitus (DM).</p> <p>Review of the physician orders for Resident #152 revealed an order dated 04/24/25 for insulin lispro inject 10 units subcutaneous (SQ) before meals related to DM, and hold if the blood sugar under 150.</p> <p>Observation on 05/13/25 at 11:21 A.M. revealed Licensed Practical Nurse (LPN) #549 placed disposable gloves on, entered Resident #152's room and assessed Resident #152's blood sugar via fingerstick. LPN #549 then returned to the medication cart, did not remove her gloves or wash her hands, documented the blood sugar results in the electronic documentation system, returned to Resident #152's room with the insulin and administered the insulin. LPN #549 then removed her gloves, returned to the medication cart. LPN #549 confirmed she left Resident #152's room wearing her gloves, documented in the computer with the gloves on, returned to the room with the same gloves and administered the insulin leaving the room once again without washing her hands or using hand sanitizer at any time during the observation.</p> <p>Review of the facility policy titled Enhanced Barrier Precautions revised 07/13/22 revealed EBP referred to the use of gown and gloves for certain residents during specific high contact resident care activities that have been found to increase the risk for transmission of multi-drug resistant organisms. Masks, gowns and gloves available immediately outside of the residents room. High contact resident care activities include providing hygiene and device care including central lines.</p> <p>Review of the facility policy titled Hand Hygiene revised 12/01/21 revealed all staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. Indications for use included between resident contacts, before performing resident procedures, after assisting with personal body functions, before applying or after removing PPE including gloves, before preparing or handling medications, and after handling items potentially contaminated with blood or body fluids.</p> <p>Review of CDC guidance titled Implementation of PPE Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs) found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html and dated 04/02/24 revealed MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. EBP are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with any of the following: wounds or indwelling medical devices, regardless of MDRO colonization status.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of CDC guidance titled Clinical Safety: Hand Hygiene for Healthcare Workers found at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html and dated 02/27/24 revealed hand hygiene protects both healthcare personnel and patients. Cleaning your hands reduces the potential spread of deadly germs to patients. Recommendations included on know when to wear (and change) gloves stated gloves are not a substitute for hand hygiene. If your tasks requires gloves, perform hand hygiene before donning gloves and touching the patient or the patients surroundings; always clean your hands after removing gloves. When to change gloves and clean hands included if gloves become soiled with blood or body fluids after a task, if moving from work on a soiled body site to a clean body site on the same patient or if clinical indication for hand hygiene occurs, and before exiting a patient room.</p>

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of personnel files, record review, and staff interview, the facility failed to ensure all staff received behavior health training. This had the potential to affect 37 residents (Residents #1, #3, #4, #5, #6, #8, #9, #10, #11, #14, #18, #19, #20, #21, #23, #24, #25, #26, #28, #29, #30, #32, #34, #36, #37, #38, #39, #40, #42, #44, #45, #47, #48, #152, #153, #303, and #304) who resided in the facility at time of entrance and had a psychiatric and/or mood diagnosis.</p> <p>Findings include:</p> <p>Review of the personnel file for Licensed Practical Nurse (LPN) #526 revealed a hire date of 10/19/21. The file contained no evidence that LPN #526 received training on mental health behaviors.</p> <p>Review of the personnel file for LPN #553 revealed a hire date of 04/16/25. The file contained no evidence that LPN #553 received training on mental health behaviors.</p> <p>Review of the personnel file for Certified Nursing Assistant (CNA) #531 revealed a hire date of 12/12/19. The file contained no evidence that CNA #531 received training on mental health behaviors.</p> <p>Review of the personnel file for Human Resource Manager (HR) #535 revealed a hire date of 02/29/25. The file contained no evidence that HR #535 received training on mental health behaviors.</p> <p>Review of the personnel file for the Administrator revealed a hire date of 06/03/24. The file contained no evidence that the Administrator received training on mental health behaviors.</p> <p>Review of the personnel file for CNA #521 revealed a hire date of 09/18/23. The file contained no evidence that CNA #521 received training on mental health behaviors.</p> <p>Review of the personnel file for CNA #545 revealed a hire date of 04/21/25. The file contained no evidence that CNA #545 received training on mental health behaviors.</p> <p>Review of the personnel file for CNA #516 revealed a hire date of 06/27/24. The file contained no evidence that CNA #516 received training on mental health behaviors.</p> <p>Review of the personnel file for CNA #540 revealed a hire date of 03/03/25. The file contained no evidence that CNA #540 received training on mental health behaviors.</p> <p>Review of the personnel file for Dietary Aide (DA) #547 revealed a hire date of 03/12/25. The file contained no evidence that DA #547 received training on mental health behaviors.</p> <p>Review of the personnel file for Activity Director (AD) #515 revealed a hire date of 04/05/21. The file contained no evidence that AD #515 received training on mental health behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility assessment dated [DATE] revealed the facility did not provide care to their residents who had psychiatric/mood disorders. However, staff interview revealed they had 37 residents who had psychiatric/mood disorders. The resident acuity affecting nurse aides revealed the nurse aides provided assistance with behavioral health symptoms. Care and assistance was provided as necessary to the resident's behavioral and mental health.</p> <p>Interview on 05/15/25 at 11:17 A.M. with Human Resource Manager (HR) #535 verified no behavioral health training was completed for LPN #526, LPN #553, CNA #531, HR #535, Administrator, CNA #521, CNA #545, CNA #516, CNA #540, DA #547, and AD #515.</p> <p>Interview on 05/15/25 at 11:32 A.M. with Director of Nursing (DON) confirmed 37 residents (Residents #1, #3, #4, #5, #6, #8, #9, #10, #11, #14, #18, #19, #20, #21, #23, #24, #25, #26, #28, #29, #30, #32, #34, #36, #37, #38, #39, #40, #42, #44, #45, #47, #48, #152, #153, #303, and #304) who resided in the facility at time of entrance had a psychiatric and/or mood diagnosis.</p> <p>This deficiency represents non-compliance investigated under Complaint Number OH00163020.</p>