STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	365672	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Care Center	2565 Niles Vienna Rd Niles, OH 44446

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on interview, record review, and facility policy review, the facility failed to treat Resident #86 with dignity and respect. This affected one resident (#86) and had the potential to affect all 106 residents who resided in the facility. Findings include: Review of the medical record for Resident #86 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus type two with neuropathy, chronic respiratory failure, tracheostomy status, disturbances of salivary secretion, gastrostomy status, essential primary hypertension and depression. Interview on 01/21/25 at 8:05 A.M. with Resident #86 complained about a recent confrontation with Licensed Practical Nurse (LPN) #287 who when questioned about her medication schedule, responded rudely and thereafter retaliated by ignoring Resident #86, giving all other residents medications first before administering hers, making them late. Resident #86 detailed the nurse's rudeness, indicating LPN #287 angrily went to the room door then shouted back at Resident #86 of knowing how to read a computer before abruptly leaving. Resident #86 stated LPN #287 thereafter was dismissive and never addressed her questions or concerns. Review of Resident #86's medication administration record (MAR) from January 2025 indicated orders dated 01/15/25 for midodrine 5 milligrams (mg) enterally three times daily for hypotension, Vistaril 50 mg enterally three times daily for anxiety, and gabapentin 300 mg enterally three times daily for difficulty in walking. All medications were scheduled for administration at early, noon and HS (bedtime). Review of Resident #86's MAR from January 2024 and medication administration audit report (MAAR) from 01/13/25 to 01/19/25 for medications administered by LPN #287 revealed the following late administrations: On 01/15/25, the noon dose of midodrine was not administered until 5:20 P.M. On 01/16/25, the noon doses of midodrine, Vistaril and gabapentin were not administered until 3:35 P.M. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365672	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/28/2025
NAME OF PROVIDER OR SUPPLIER: Autumn Hills Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 2565 Niles Vienna Rd, Niles, OH 44446	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/18/25, the noon doses of midodrine, Vistaril and gabapentin were not administered until 3:21 P.M. On 01/19/25, the noon doses of midodrine, Vistaril and gabapentin were not administered until 3:14 P.M. Interview on 01/23/25 at 8:14 A.M. with Director of Nursing (DON) verified the above medication administration findings. Interview on 01/23/25 at 10:22 A.M. with LPN #287 via telephone confirmed a confrontation with Resident #86 had occurred including shouting back at the resident about knowing how to read a computer. LPN #287 presented as defensive, dismissive and curt during the interview. When questioned for clarification of facts, LPN #287 responded, Do not ask me questions three times in different ways. I answered the question already. When asked as to why LPN #287 was contentious, LPN #287 retorted, Sorry I don't have a cute mousey voice. LPN #287's combativeness impeded the survey process, so the interview was concluded. Therefore, further investigation could not be completed. Review of facility policy, Medication Administration Schedule, dated July 2016, revealed early was a routine schedule of 6:00 A.M. to 10:00 A.M., noon was 11:00 A.M. to 2:00 P.M., PM was 3:00 P.M. to 7:00 P.M. and HS was 8:00 P.M. to 12:00 A.M. Review of the undated facility policy, Medication Administration - General Guidelines revealed medications were administered within 60 minutes of scheduled times. This deficiency represents non-compliance investigated under Master Complaint Number OH00161540 and Complaint Number OH00161212.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, record review, review of photographs provided by Resident #27's fiancee/power of attorney (POA) and facility policy review, the facility failed to develop and implement a comprehensive and individualized pressure ulcer prevention program to prevent the development of pressure ulcers and timely identify new pressure ulcers, including timely incontinence care and turning and repositioning. This affected two residents (#27 and #109) of two residents reviewed for pressure ulcers. The facility census was 106. Actual Harm occurred on 12/19/24 when Resident #27, who had a history of a pressure ulcer, quadriplegic and in a persistent vegetative state, was dependent on staff assistance for all activities of daily living (ADL) including toileting, hygiene, showers, dressing, transfers, and rolling left and right in bed, was found to have an in-house acquired Stage III pressure ulcer (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) to his sacrum that contained 30 percent slough/necrosis (dead tissue). The facility failed to provide documented evidence of effective, comprehensive, and adequate interventions being in place to prevent the development of this pressure ulcer and to ensure the pressure ulcer was identified before being found at a Stage III. Actual Harm occurred on 01/16/25 when Resident #109, who was dependent on staff for all ADL care including toileting, hygiene, showers, dressing, and rolling left and right in bed, was found to have an in-house acquired unstageable (full thickness tissue loss in which the actual depth of the ulcer was obscured by slough/ dead skin) pressure ulcer to his left lateral foot that contained 100 percent dry eschar firmly adhered. The facility failed to provide documented evidence of effective, comprehensive, and adequate interventions being in place to prevent the development of this pressure ulcer and to ensure the pressure ulcer was identified before being found at unstageable. Findings include: 1. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including anoxic brain damage, chronic respiratory failure, quadriplegia, and persistent vegetative state. Review of the care plan dated 12/05/24 revealed Resident #27 was dependent on staff with ADL due to anoxic brain damage, persistent vegetative state quadriplegia. Interventions included turning and repositioning every two hours, staff to provide incontinence care with routine rounds, and staff to provide all care as he was dependent and does not participate in any aspect of his ADL. Review of the care plan dated 12/05/24 revealed Resident #27 was at risk for impaired skin integrity secondary to bowel and bladder incontinence and impaired mobility, and he required total staff dependence for all his care needs. Interventions included elevating heels off mattress, inspecting skin during routine daily care, lift sheet on chair/bed for positioning, lotion to skin as needed, incontinence care after each incontinent episode, pressure reduction mattress to bed, and treatments as ordered. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the CHS Admission Packet V13.1 dated 12/05/24 and completed by Wound Nurse/Licensed Practical Nurse (LPN) #209 and LPN #287 revealed on admission Resident #27 was in a comatose state and his skin was warm, dry and within normal limits. He had a left buttock open area, but no description was noted in the assessment. There was no skin integrity issues noted to his sacral area. (There was no further reference to any area on his left buttock in the medical record). Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #27 had impaired cognition. He was dependent on staff for all ADL, including rolling left and right, toileting hygiene, personal hygiene, transfers, and showers. He was always incontinent with bowel and bladder and was at risk for developing pressure ulcers but had no unhealed pressure ulcers on admission. Review of the Braden Scale for Predicting Pressure Sore Risk dated 12/12/24 and completed by Wound Nurse/LPN #209 revealed Resident #27 was at very high risk for the development of pressure ulcers as he was completely limited with sensory perception, very moist, bedfast, completely immobile, and had a problem with friction and shearing. Review of the Skin Grid Pressure 3.0-V2 dated 12/19/24 and completed by Wound Nurse/LPN #209 revealed on 12/18/24, Resident #27 was identified to have a new Stage III pressure ulcer to his sacrum area that measured of 5.5-centimeter (cm) length by 6.1 cm width by 0.3 cm depth. The assessment described the area as: several open areas across the sacrum among scar tissue from a previously healed pressure wound. There was thin slough with granulating tissue with scattered areas of moist tissue at wound edges. The wound had moderate drainage. Review of the nursing note dated 12/19/24 at 3:00 P.M. and completed by Wound Nurse/LPN #209 revealed she noticed a new Stage III pressure injury to Resident #27's sacrum area with scar tissue surrounding the wound indicating he had a previous pressure area to this area. The nursing note revealed she ordered an air mattress and to off-load the pressure with wedges. Review of the care plan dated 12/19/24 revealed Resident #27 had actual impaired skin integrity as he had a Stage III pressure ulcer to his sacrum which the family had reported he had a wound there a few years ago. Interventions included wound care per physician orders, referring to a wound physician, low air loss mattress on the bed, and ensure Resident #27 was turned and repositioned per orders. Review of Wound Nurse Practitioner (NP) #318's progress note dated 12/19/24 revealed this was the first time she consulted for Resident #27 and noted Resident #27 to have a Stage III pressure ulcer to his sacrum area that measured 5.5 cm length by 6.1 cm by 0.3 cm depth. The wound contained 30 percent slough. She revealed even though there was slough/eschar present it did not obscure the extent of tissue loss; therefore, it was acceptable to classify this wound as a Stage III. She noted several open areas across his sacrum among scar tissue related to previously healed pressure wound. The note revealed that the family had reported he had a previous wound to his sacrum a few years ago that healed. (There was no documentation in her progress note regarding the wound being unavoidable). Review of the facility form labeled Unavoidable Pressure Injury dated 12/19/24 revealed Resident #27's pressure ulcer was unavoidable because the resident had impaired mobility, bowel incontinence, quadriplegia and had a prior history of pressure ulcer in the same location. The physician signature line had NP #317's printed name. (continued on next page)

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Review of the undated pictures taken by Resident #27's fiancee/ POA revealed three pictures: 1. A picture of a blue incontinence brief heavily saturated in urine with dark yellow and brown urine in it. The picture appeared that Resident #27 had urinated multiple times in the brief. 2. A picture with the white washable incontinence pad that had a large brown urine ring underneath Resident #27's buttocks. 3. A picture of linen with brown, yellow discoloration appearing from urine. Resident #27's fiancee/ POA stated she had taken the pictures 12/22/24 at 6:18 P.M.

Review of text message from Resident #27's fiancee/ POA to Director of Nursing (DON) dated 12/23/24 at 8:50 A.M. revealed my concerns are still there after I spoke with you my fiancee lays there in pee and the changing supposed to be every two hours but guess what I'm there for hours at a time without him getting changed. I pulled a nasty diaper off him with a chuck also soaked to the core through and about ten pounds the night before and yesterday.

Review of the Skin Grid Pressure 3.0-V2 dated 01/16/25 and completed by Wound Nurse/LPN #209 revealed Resident #27 continued to have a Stage III pressure area to his sacrum area that measured 0.9 cm length by 0.6 cm width by 0.3 cm depth. The area improved with dark pink granulating tissue present and moderate drainage.

Interview on 01/21/25 at 9:41 A.M. with LPN #221 revealed there had been issues with incontinence care getting done. She revealed there was a problem last night as when she came in there were multiple rooms where resident's incontinence briefs excessively filled with urine indicating the residents were not changed. She revealed the urine had leaked out of the incontinence briefs onto the bed linens requiring several full linen bed changes. She revealed many of the linen changes had brown rings.

Interview on 01/21/25 at 10:08 A.M. and 01/22/25 at 4:49 P.M. with Resident #27's fiancee/ POA revealed Resident #27 was admitted to the facility with intact skin. She was upset as she came in almost daily and frequently found him with saturated incontinence briefs, and dried brown urine-soaked linens indicating he was not being changed timely as well as when she was in the facility for long periods of time, he was not being turned and repositioned every two hours as he needed to be. She revealed she took multiple pictures of the incontinence briefs and linens and showed the pictures and brought up her concerns to the DON. She revealed Resident #27 then developed a large pressure ulcer to his sacrum which she believed never should have happened if he was being changed and turned as he needed. She verified the pictures of the saturated blue incontinence brief, washable incontinence pad with large brown ring underneath Resident #27's buttocks were soaked with urine and the linen with brown, yellow discoloration appearing from urine were taken on 12/22/24 at 6:18 P.M.

Interview on 1/21/25 at 11:21 A.M. and 3:20 P.M. with Wound Nurse/LPN #209 verified Resident #27's pressure ulcer to his sacrum was first identified at Stage III and contained 30 percent slough tissue. She was unable to provide a reason why the wound was not identified before it was Stage III. She revealed she did not see him daily and was not at the facility 24 hours a day, so she was unable to say if he was being provided with timely incontinence care and/or turned and repositioned every two hours but believed that he was.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Interview on 01/21/25 at 2:22 P.M. and 2:44 P.M. with the DON verified Resident #27's fiancee/ POA showed her pictures as well as communicated her concern to her that Resident #27 was not getting turned and repositioned or changed timely. She was shown the pictures and verified the blue incontinence brief was heavily saturated in urine with yellow and brown urine in it. She verified the picture appeared he was not changed in a timely manner. She stated, I do not really have an explanation of why but that was why the facility proceeded to go to a condom catheter (a urine collection device that fits like a condom over the penis and has a tube to drain the urine). She then verified the pictures with the white washable incontinence pad that had a large brown ring underneath Resident #27's buttocks and the linen with brown, yellow discoloration appearing from urine. She again stated she had no explanation and again stated that was why the facility went with a condom catheter. Interview on 01/22/25 at 9:42 A.M. with NP #317 regarding the facility form labeled Unavoidable Pressure Injury dated 12/19/24 revealed Resident #27's pressure ulcer was unavoidable because the resident had impaired mobility, bowel incontinence, quadriplegia and had a prior history of pressure ulcer in the same location. The physician signature line had NP #317's printed name. She stated she had never seen this form prior and verified she had not filled out this form and never discussed Resident #27's wound with the facility. She did not get involved with the wounds because the facility had a wound company that came in and handled the wounds at the facility. Observation of wound care on 01/22/25 at 9:58 A.M. revealed Assistant Director of Nursing (ADON)/Registered Nurse (RN) #309 changed Resident #27's wound dressing to his sacrum area according to the physician order. She described the wound bed as red with minimal drainage and no signs of infection. Interview on 01/22/25 at 10:45 A.M. with DON revealed she was not aware Wound Nurse/LPN #209 had printed NP #317's name on the form in the area of physician's signature. She verified she had spoken with NP #317 who also confirmed to her that she had not signed the form and/or had any discussion with the facility regarding Resident #27's wound status. She revealed she felt it was a mistake but could not speak about why this was done at this time as currently Wound Nurse/LPN #209 was on suspension. 2. Review of the closed medical record for Resident #109 revealed an admitted [DATE], and he was discharged to the hospital on 01/19/25. His diagnoses included acute and chronic respiratory failure with hypoxia, dependence on a respiratory ventilator, and hemiplegia and hemiparesis following cerebrovascular disease effecting his left dominant side. Review of the CHS Admission Packet V13.1 dated 12/11/24 and completed by Wound Nurse/LPN #209 and LPN #287 revealed Resident #109 was disoriented, nonverbal, and had severe cognitive impairment. He had a deep tissue injury (DTI) (purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue due to pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.) to his coccyx, left buttock and right buttock and a pressure ulcer to his left hip region. There was no skin impairment identified to his bilateral lower feet. Review of the care plan dated 12/11/24 revealed Resident #109 was admitted with impaired skin integrity/pressure ulcers. He was unable to reposition himself. Interventions included elevating heels off the mattress, inspecting skin during routine daily care, lotion to skin as needed, pillows for positioning, skin assessments as ordered, turn and reposition as ordered, and pressure reduction devices if ordered. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the care plan dated 12/12/24 revealed Resident #109 required staff assistance for his ADL related to ventilator and tracheostomy dependent. Interventions were identified as staff to assist with daily hygiene, and staff to adjust care as needed to meet resident's needs. Review of the admission MDS assessment dated [DATE] revealed Resident #109 was dependent on staff to roll him left and right, toileting hygiene, personal hygiene, and showers. Review of the Braden Scale for Predicting Pressure Sore Risk dated 12/19/24 revealed Resident #109 was at high risk for developing pressure ulcers because he was very limited to sensory perception, very moist, bedfast, very limited to mobility, and had a problem with friction and shear. Review of the previous Skin Grid Pressure 3.0-V2 dated 12/12/24, 12/19/24, 12/26/24, 01/02/25, and 01/09/24 revealed no documented evidence of any identified concerns to Resident #109's left lateral foot. Review of the Skin Grid Pressure 3.0-V2 dated 01/16/25 and completed by Wound Nurse/LPN #209 revealed Resident #109 had an unstageable pressure ulcer to his left lateral foot that measured 2.5 cm in length by 2.0 cm width by depth was unable to be determined. The assessment described the wound as having firmly adhered dry eschar. Review of the nursing note dated 01/16/25 at 9:51 A.M. and completed by Wound Nurse/LPN #209 revealed she contacted Resident #109's daughter for permission for Resident #109 to see Wound NP #318. Resident #109's daughter agreed. There was no other documentation in the nursing notes regarding Resident #109's pressure ulcer to his left lateral foot. Review of Wound NP #318's progress note dated 01/16/25 revealed this was Wound NP #318's initial consultation. Resident #109 had an unstageable left lateral foot pressure ulcer that was measured 2.5 cm length by 2.0 cm width by depth was unable to be determined. The wound was described to have 100 percent dry firmly adhered eschar. She that this wound was present on admission. Review of the January 2025 physician order revealed Resident #109 had an order dated 01/17/25 to cleanse the left lateral foot with normal saline, apply Skin Prep (forms a protective barrier) and leave open to air every day-on-day shift. Interview on 01/22/25 at 10:45 A.M. with the DON verified Resident #109's left lateral pressure ulcer to his foot was facility acquired as it was first identified as an unstageable pressure ulcer on 01/16/25 per the documentation, and that it contained 100 percent dry, firmly adhered eschar. She revealed she could not explain why it was found as unstageable and not at an earlier stage, especially since Resident #109 was dependent on staff for all ADL. Interview on 01/22/25 at 1:20 P.M. with Wound NP #318 revealed the first time she consulted for Resident #109 was on 01/16/25. She verified she documented on her progress note that Resident #109's unstageable pressure to the left lateral foot was present on admission and stated that was what Wound Nurse/LPN #209 told her. She verified she did not realize the first documentation of this area was on 01/16/25. She verified when she initially saw the wound to the left lateral foot on -1/16/25, it was unstageable with 100 percent dry eschar. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the undated facility policy labeled, Pressure Ulcer Prevention and Risk Identification revealed the facility would assess each resident for risk of pressure ulcer development in an effort to establish measures to prevent the development of pressure ulcers within the facility. A pressure ulcer risk assessment for each resident would be completed upon admission and weekly times four weeks and preventative measures would be implemented based on the resident's assessed need and risk score. The policy revealed a care plan would be developed and updated routinely with identified skin risk and/or actual wound development. Interventions would be implemented as indicated by the physician and as determined by the interdisciplinary team. This deficiency represents non-compliance investigated under Complaint Number OH00161212.

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F 0690

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39973

Based on observation, interview, record review, review of photographs provided by Resident #27's fiancee/power of attorney (POA) and facility policy review revealed the facility failed to provide timely incontinence care. This affected four residents (#1, #27, #54, and #57) out of seven residents reviewed for incontinence care and had the potential to affect 76 residents (#1, #2, #3, #4, #5, #7, #8, #9, #12, #13, #15, #16, #17, #18, #20, #21, #22, #23, #24, #26, #27, #29, #30, #31, #32, #33, #35, #36, #37, #38, #39, #40, #42, #43, #45, #48, #50, #51, #52, #53, #54, #55, #56, #57, #59, #60, #62, #63, #66, #67, #68, #69, #70, #71, #72, #74, #75, #76, #78, #81, #82, #83, #84, #85, #87, #91, #94, #86, #97, #99, #100, #101, #102, #103, #107, and #108) identified by the facility that required assistance with incontinence care. The facility census was 106.

Findings include:

1. Review of the medical record for Resident #54 revealed an admitted [DATE] with diagnoses including diabetes, heart failure, morbid obesity, and hypertension.

Review of the Medicare five-day Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #54 had intact cognition and was dependent on staff with her toileting hygiene. She was always incontinent of bowel and bladder.

Review of the care plan last revised 01/21/25 revealed Resident #54 was incontinent of urine. Interventions included assistance with toileting and incontinence care as needed, barrier cream as needed and monitor for signs of urinary tract infection.

Interview on 01/21/25 at 9:42 A.M. with Resident #54 revealed she felt the facility was understaffed as it was hard to get changed and provided with timely incontinence care. She revealed she was currently lying in urine and bowel movement as she stated she told the aide at 9:15 A.M. that she needed changed but was still waiting. She revealed the aide stated she needed to pick up the breakfast trays before she could change her. She revealed the last time she was changed was at 6:00 A.M. She verified she does not get changed every two hours as she required, especially because she was on diuretics (medications that caused increased urination).

Interview on 01/21/25 at 9:45 A.M. revealed Certified Nursing Assistant (CNA) #211 walked into Resident #54 room to provide Resident #54 incontinence care. She revealed she was assigned Resident #54's care and had come in at 7:00 A.M. She had to pass trays and then collect the trays before she really could start any type of care including incontinence care. She had not provided any incontinence care for Resident #54 since she had arrived on duty and verified, she was aware at 9:15 A.M. that Resident #54 requested to be changed. She stated, with the number of residents she was assigned, she was not able to get to everyone in a timely manner.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 01/21/25 at 9:45 A.M. of incontinence care completed by CNA #211 for Resident #54 revealed she was wearing an incontinence liner as well as an incontinence brief that both contained large amounts of urine and bowel movement. CNA #211 verified both incontinence products were saturated and stated, just, we get no help, there is no way to change everyone every two hours. She verified the last time Resident #54 was changed was most likely at 6:00 A.M. as Resident #54 stated and verified her incontinence products appeared as she had urinated multiple times due to how wet and heavy they were. 2. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including anoxic brain damage, chronic respiratory failure, quadriplegia, and persistent vegetative state. Review of the care plan dated 12/05/24 revealed Resident #27 was dependent on staff with his activities of daily living (ADL) due to anoxic brain damage, persistent vegetative state, and he was a quadriplegic. Interventions included staff providing incontinence care with routine rounds, and staff providing all care as he was dependent and did not participate in any aspect of his ADL. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #27 had impaired cognition, and he was dependent on staff for his toileting hygiene. He was always incontinent with bowel and bladder. Review of undated pictures taken by Resident #27's fiancee/POA revealed three pictures: 1. A picture of a blue incontinence brief heavily saturated in urine with dark yellow and brown urine in it. The picture appeared that Resident #27 had urinated multiple times in the brief. 2. A picture with the white washable incontinence pad that had a large brown urine ring underneath Resident #27's buttocks. 3. A picture of linen with brown, yellow discoloration appearing from urine. Resident #27's fiancee/ POA stated she had taken the pictures 12/22/24 at 6:18 P.M. Review of text message from Resident #27's fiancee/POA to Director of Nursing (DON) dated 12/23/24 at 8:50 A.M. revealed my concerns are still there after I spoke with you my fiancee lays there in pee and the changing supposed to be every two hours but guess what I'm there for hours at a time without him getting changed. I pulled a nasty diaper off him with a chuck also soaked to the core through and about ten pounds the night before and yesterday. Interview on 01/21/25 at 10:08 A.M. and 01/22/25 at 4:49 P.M. with Resident #27's fiancee/POA revealed Resident #27 was admitted to the facility with intact skin. She was upset as she came in almost daily and frequently found him with saturated incontinence briefs, and dried brown urine-soaked linens indicating he was not being changed timely as well as when she was in the facility for long periods of time. She revealed she took multiple pictures of the incontinence briefs and linens as well as showed the pictures and brought up her concern to the DON. She verified the pictures of the saturated blue incontinence brief, washable incontinence pad with large brown ring underneath Resident #27's buttocks were soaked with urine and the linen with brown, yellow discoloration appearing from urine were taken on 12/22/24 at 6:18 P.M. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Autumn Hills Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2565 Niles Vienna Rd Niles, OH 44446	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/21/25 at 2:22 P.M. and 2:44 P.M. with the DON verified Resident #27's fiancee/POA showed her pictures as well as communicated her concern to her that Resident #27 was not getting turned and repositioned or changed timely. The DON was shown the pictures and verified the blue incontinence brief was heavily saturated in urine with yellow and brown urine in it. She verified the picture appeared he was not changed in a timely manner. She stated, I do not really have an explanation of why but that was why the facility proceeded to go to a condom catheter (a urine collection device that fits like a condom over the penis and has a tube to drain the urine). She then verified the pictures with the white washable incontinence pad that had a large brown ring underneath Resident #27's buttocks and the linen with brown, yellow discoloration appearing from urine. She again stated she had no explanation and again stated that was why the facility went with a condom catheter. 3. Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnoses including cirrhosis of the liver, diabetes, chronic obstructive pulmonary disease and morbid obesity. Review of the care plan dated 11/05/23 revealed Resident #57 was at risk for skin integrity/pressure ulcers due to decreased mobility and bladder incontinence. Interventions included perineal care after each incontinent episode and barrier cream after each incontinence episode as needed. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #57 had intact cognition, and she was dependent on staff with toileting hygiene. She was always incontinent of bowel and bladder. Interview on 01/21/25 at 9:41 A.M. with Licensed Practical Nurse (LPN) #221 revealed there had been issues with incontinence care getting done. She revealed there was a problem last night as when she came in, there were multiple residents, including Resident #57, where their incontinent briefs were excessively filled with urine indicating the residents were not changed. She revealed the urine had leaked out of the incontinence briefs onto the bed linens requiring several full linen bed changes. She revealed many of the linen changes had brown rings. She verified Resident #57 was one of the residents who appeared that she was not changed all night. Interview on 01/21/25 at 10:19 A.M. with Resident #57 revealed she was not provided any incontinence care last night during the night shift. 4. Review of the medical record for Resident #1 revealed an admitted d of 11/07/24 with diagnoses including anoxic brain damage, respiratory failure with hypoxia, multiple sclerosis, and persistent vegetive state. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #1 had impaired cognition and was dependent on staff for toileting hygiene. Review of the undated care plan revealed Resident #1 was incontinent of bladder and required total staff dependence with all care. Intervention included assistance with toileting and incontinence care as needed, and barrier cream as needed. (continued on next page)

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	365672	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Hills Care Center	2565 Niles Vienna Rd Niles, OH 44446

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/21/25 at 9:41 A.M. with LPN #221 revealed there had been issues with incontinence care getting done. She revealed there was a problem last night as when she came in there were multiple residents, including Resident #1, where their incontinent briefs were excessively filled with urine indicating the residents were not changed. She revealed the urine had leaked out of the incontinence briefs onto the bed linens requiring several full linen bed changes. She revealed many of the linen changes had brown rings. She verified Resident #1 was one of the residents who appeared that she was not changed all night. 5. Interview on 01/21/25 at 9:53 A.M. with Resident #39 revealed often the night shift aides did not come in and change her, even if she rang for assistance, they just come in and turn off her light without changing her. She revealed she was left lying in a mess for a long time. Interview on 01/22/25 at 2:35 P.M. with CNA #255 revealed she worked day shift 7:00 A.M. to 7:00 P.M. and on her current assignment, she had approximately 19 residents and most required incontinence care. She revealed the assignment was too heavy, and that she was not able to get to all the residents incontinence care was completed in a timely manner. She stated, it is impossible to get to everyone in a timely manner. Interview on 01/23/25 at 8:05 A.M. with Resident #107 revealed she was not changed and provided incontinence care routinely, especially not every two hours. She stated, I have had to lie in urine for quite a while. She revealed she rings her call light to be changed but had to wait 45 minutes to an hour to get changed as the staff was too busy to change her. Review of the undated facility policy labeled, Incontinence Care revealed the purpose of the policy was to maintain skin integrity, prevent skin breakdown, control odors, and provide comfort and self-esteem. The policy revealed after each episode of incontinence cleanse area with perineal wash or mild cleanser. This deficiency represents non-compliance investigated under Complaint Number OH00161212.

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 39973

Based on observation, interview, record review, facility assessment, review of photographs provided by Resident #27's fiancee/power of attorney (POA) and facility policy review, the facility failed to have adequate staffing to meet the needs of the residents. This affected four residents (#1, #54, #57, and #107) out of four residents reviewed on the 200 assignment (rooms 211 to 229) and one resident (#29) out of two residents reviewed for staffing in regard to prevention of pressure ulcers. The facility census was 106.

Findings include:

1. Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including anoxic brain damage, chronic respiratory failure, quadriplegia, and persistent vegetative state.

Review of the care plan dated 12/05/24 revealed Resident #27 was dependent on staff with activities of daily living (ADL) due to anoxic brain damage, persistent vegetative state quadriplegia. Interventions included turning and repositioning every two hours, staff to provide incontinence care with routine rounds, and staff to provide all care as he was dependent and did not participate in any aspect of his ADL.

Review of the care plan dated 12/05/24 revealed Resident #27 was at risk for impaired skin integrity secondary to bowel and bladder incontinence and impaired mobility, and he required total staff dependence for all his care needs. Interventions included elevating heels off mattress, inspecting skin during routine daily care, lift sheet on chair/bed for positioning, lotion to skin as needed, incontinence care after each incontinent episode, pressure reduction mattress to bed, and treatments as ordered.

Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #27 had impaired cognition. He was dependent on staff for all ADL, including rolling left and right, toileting hygiene, personal hygiene, transfers, and showers. He was always incontinent with bowel and bladder and was at risk for developing pressure ulcers but had no unhealed pressure ulcers on admission.

Review of the Skin Grid Pressure 3.0-V2 dated 12/19/24 and completed by Wound Nurse/Licensed Practical Nurse (LPN) #209 revealed on 12/18/24, Resident #27 was identified to have a new Stage III (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) pressure ulcer to his sacrum area that measured of 5.5-centimeter (cm) length by 6.1 cm width by 0.3 cm depth. The assessment described the area as: several open areas across the sacrum among scar tissue from a previously healed pressure wound. There was thin slough with granulating tissue with scattered areas of moist tissue at the wound edges. The wound had moderate drainage.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the undated pictures taken by Resident #27's fiancee/POA revealed three pictures: 1. A picture of a blue incontinence brief heavily saturated in urine with dark yellow and brown urine in it. The picture appeared that Resident #27 had urinated multiple times in the brief. 2. A picture with the white washable incontinence pad that had a large brown urine ring underneath Resident #27's buttocks. 3. A picture of linen with brown, yellow discoloration appearing from urine. Resident #27's fiancee/POA stated she had taken the pictures 12/22/24 at 6:18 P.M. Review of the text message from Resident #27's fiancee/POA to Director of Nursing (DON) dated 12/23/24 at 8:50 A.M. revealed my concerns are still there after I spoke with you my fiancee lays there in pee and the changing supposed to be every two hours but guess what I'm there for hours at a time without him getting changed. I pulled a nasty diaper off him with a chuck also soaked to the core through and about ten pounds the night before and yesterday. Interview on 01/21/25 at 10:08 A.M. and 01/22/25 at 4:49 P.M. with Resident #27's fiancee/POA revealed Resident #27 was admitted to the facility with intact skin. She was upset as she came in almost daily and frequently found him with saturated incontinence briefs, and dried brown urine-soaked linens indicating he was not being changed timely. She was in the facility for long periods of time, he was not being turned and repositioned every two hours as he needed to be. She took multiple pictures of the incontinence briefs and linens and showed the pictures and brought up her concerns to the DON. She revealed Resident #27 then developed a large pressure ulcer to his sacrum which she believed never should have happened if he was being changed and turned as he needed. She verified the pictures of the saturated blue incontinence brief, washable incontinence pad with large brown ring underneath Resident #27's buttocks were soaked with urine and the linen with brown, yellow discoloration appearing from urine were taken on 12/22/24 at 6:18 P. M. She felt there were not enough staff to take care of his needs. Interview on 1/21/25 at 11:21 A.M. and 3:20 P.M. with Wound Nurse/LPN #209 verified Resident #27's pressure ulcer to his sacrum was first identified at Stage III and contained 30 percent slough tissue. She was unable to provide a reason why the wound was not identified before it was Stage III. She revealed she did not see him daily and was not at the facility 24 hours a day, so she was unable to say if he was being provided with timely incontinence care and/or turned and repositioned every two hours but believed that he was. Interview on 01/21/25 at 2:22 P.M. and 2:44 P.M. with the DON verified Resident #27's fiancee/POA showed her pictures as well as communicated her concern to her that Resident #27 was not getting turned and repositioned or changed timely. She was shown the pictures and verified the blue incontinence brief was heavily saturated in urine with yellow and brown urine in it. She verified the picture appeared he was not changed in a timely manner. She stated, I do not really have an explanation of why but that was why the facility proceeded to go to a condom catheter (a urine collection device that fits like a condom over the penis and has a tube to drain the urine). She then verified the pictures with the white washable incontinence pad that had a large brown ring underneath Resident #27's buttocks and the linen with brown, yellow discoloration appearing from urine. She again stated she had no explanation and again stated that was why the facility went with a condom catheter. 2. Review of the medical record for Resident #54 revealed an admitted [DATE] with diagnoses including diabetes, heart failure, morbid obesity, and hypertension. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medicare five-day MDS 3.0 assessment dated [DATE] revealed Resident #54 had intact cognition and was dependent on staff with toileting hygiene. She was always incontinent of bowel and bladder. Review of the care plan last revised 01/21/25 revealed Resident #54 was incontinent of urine. Interventions included assistance with toileting and incontinence care as needed, barrier cream as needed and monitor for signs of urinary tract infection. Interview on 01/21/25 at 9:42 A.M. with Resident #54 revealed she felt the facility was understaffed as it was hard to get changed and provided with timely incontinence care. She revealed she was currently lying in urine and bowel movement stating, she told the aide at 9:15 A.M. that she needed changed but was still waiting. She revealed the aide stated she needed to pick up the breakfast trays before she could change her. She revealed the last time she was changed was at 6:00 A.M. She verified she does not get changed every two hours as required, especially because she was diuretics (medications that caused increased urination). Interview on 01/21/25 at 9:45 A.M. revealed Certified Nursing Assistant (CNA) #211 walked into Resident #54's room to provide Resident #54 incontinence care. She revealed she was assigned Resident #54's care and came in at 7:00 A.M. She revealed she had to pass trays and then collect the trays before she could start any type of care including incontinence care. She had not provided any incontinence care for Resident #54 since she arrived on duty and verified, she was aware at 9:15 A.M. that Resident #54 requested to be changed. She revealed her assignment was from room [ROOM NUMBER] to room [ROOM NUMBER]. She revealed with the number of residents she was assigned, she was not able to get to everyone in a timely manner. Observation on 01/21/25 at 9:45 A.M. of incontinence care completed by CNA #211 for Resident #54 revealed she was wearing an incontinence liner as well as an incontinence brief that both contained large amounts of urine and bowel movement. CNA #211 verified both incontinence products were saturated and stated, just, we get no help, there is no way to change everyone every two hours. She verified the last time Resident #54 was changed was most likely at 6:00 A.M. as Resident #54 stated and verified her incontinence products appeared as she had urinated multiple times due to how wet and heavy they were. 3. Review of the medical record for Resident #57 revealed an admitted [DATE] with diagnoses including cirrhosis of the liver, diabetes, chronic obstructive pulmonary disease and morbid obesity. Review of the care plan dated 11/05/23 revealed Resident #57 was at risk for skin integrity/pressure ulcers due to decreased mobility and bladder incontinence. Interventions included perineal care after each incontinent episode and barrier cream after each incontinence episode as needed. Review of the annual MDS 3.0 assessment dated [DATE] revealed Resident #57 had intact cognition, and she was dependent on staff with toileting hygiene. She was always incontinent of bowel and bladder. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 01/21/25 at 9:41 A.M. with LPN #221 revealed there had been issues with incontinence care getting done. She revealed there was a problem last night as when she came in there were multiple residents, including Resident #57, where their incontinent briefs were excessively filled with urine indicating the residents were not changed. She revealed the urine had leaked out of the incontinence briefs onto the bed linens requiring several full linen bed changes. She revealed many of the linen changes had brown rings. She verified Resident #57 was one of the residents who appeared that she was not changed all night. Interview on 01/21/25 at 10:19 A.M. with Resident #57 revealed she was not provided any incontinence care last night during the night shift. 4. Review of the medical record for Resident #1 revealed an admitted d 11/07/24 with diagnoses including anoxic brain damage, respiratory failure with hypoxia, multiple sclerosis, and persistent vegetative state. Review of the admission MDS 3.0 assessment dated [DATE] revealed Resident #1 had impaired cognition and was dependent on staff for her toileting hygiene. Review of an undated care plan revealed Resident #1 was incontinent of bladder and required total staff dependence with all her care. Intervention included assistance with toileting and incontinence care as needed, and barrier cream as needed. Interview on 01/21/25 at 9:41 A.M. with LPN #221 revealed there had been issues with incontinence care getting done. She revealed there was a problem last night as when she came in there were multiple residents, including Resident #1, where their incontinent briefs were excessively filled with urine indicating the residents were not changed. She revealed the urine had leaked out of the incontinence briefs onto the bed linens requiring several full linen bed changes. She revealed many of the linen changes had brown rings. She verified Resident #1 was one of the residents who appeared that she was not changed all night. 5. Review of medical record for Resident #107 revealed an admitted [DATE] with diagnoses including respiratory failure with hypoxia, diabetes, and morbid obesity. Her Medicare five-day MDS 3.0 assessment was still in progress. Review of the CHS Admission Packet V13.1 dated 01/18/25 and completed by LPN #213 revealed Resident #107 was cognitively intact and was incontinent of urine. Review of the care plan dated 01/18/25 revealed Resident #107 was at risk for impaired skin integrity due to difficulty walking, muscle weakness, and renal disease. Interventions included perineal care after each incontinent episode and barrier cream as needed. Interview on 01/23/25 at 8:05 A.M. with Resident #107 (who was on the same assignment that CNA #211 and CNA #255 were assigned) revealed she was not changed and provided incontinence care routinely especially not every two hours. She stated, I have had to lie in urine for quite a while. She revealed she rings her call light to be changed but had to wait 45 minutes to an hour to get changed as the staff were too busy to change her. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Interview on 01/22/25 at 2:35 P.M. with CNA #255 revealed she worked day shift 7:00 A.M. to 7:00 P.M., and she was currently assigned from room [ROOM NUMBER] to 229. She revealed on her current assignment she had approximately 19 residents and most required assistance with toileting and/or incontinence care. She revealed the assignment was too heavy, and that she was not able to get to all the residents in a timely manner to ensure incontinence care was completed. She stated, it is impossible to get to everyone in a timely manner. Interview on 01/22/25 at 3:30 P.M. with the DON verified CNA #211's assignment on 01/21/25 from 7:00 A. M. to 7:00 P.M. was from room [ROOM NUMBER] to room [ROOM NUMBER]. She verified that there was a total of 20 residents on this assignment and of the 20 residents, 14 residents required incontinence care including: Residents #1, #13, #22, #30, #45, #50, #53, #54, #57, #72, #75, #100, #101, and #107. She verified CNA #255's assignment on 01/22/25 from 7:00 A.M. to 7:00 P.M. was from room [ROOM NUMBER] to 229 and she had 18 residents on her assignment and of the 18 residents, 12 residents required incontinence care including: Residents #1, #13, #22, #30, #45, #53, #54, #57, #72, #75, #100, and #107. She verified during mealtimes it most likely was difficult to get to each resident in a timely manner but stated that was when she expected the nurse, management or other staff to assist the aide assigned to this assignment. She revealed this was a heavy assignment and revealed that the facility would take a look at the number of residents on this assignment especially the number of residents that required assistance with incontinence care. Review of the Daily Assignment Sheet dated 01/21/25 revealed CNA #211 was assigned 200 and 300. There were no room numbers regarding her exact assignment. Review of the Daily Assignment Sheet: dated 01/22/25 revealed CNA #255 was assigned 200 and 300. There were no room numbers regarding her exact assignment. Review of the undated facility policy labeled, Incontinence Care revealed the purpose of the policy was to maintain skin integrity, prevent skin breakdown, control odors, and provide comfort and self-esteem. The policy revealed after each episode of incontinence cleanse area with perineal wash or mild cleanser. Review of the undated facility policy labeled, Pressure Ulcer Prevention and Risk Identification revealed the facility would assess each resident for risk of pressure ulcer development in an effort to establish measures to prevent the development of pressure ulcers within the facility. A pressure ulcer risk assessment for each resident would be completed upon admission and weekly times four weeks, and preventative measures would be implemented based on the resident's assessed need and risk score. The policy revealed a care plan would be developed and updated routinely with identified skin risk and/or actual wound development. Interventions would be implemented as indicated by the physician and as determined by the interdisciplinary team. Review of the facility assessment dated [DATE] revealed on the 200 unit there were to be two to three CNAs per 16 residents, and the 300 unit was to include one to two CNAs per 13.3 residents. The staffing levels were based upon the acuity of the residents and the residents' population. The staffing pattern fluctuates depending on census and resident needs. This deficiency represents non-compliance investigated under Master Complaint Number OH00161540 and Complaint Number OH00161212.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41526 Based on interview, record review, and facility policy review, the facility failed to administer medications as ordered by the prescriber. This affected three residents (#1, #27 and #86) out of three residents reviewed for medication administration and had the potential to affect all 106 residents residing in the facility. Findings include: 1. Review of the medical record for Resident #1 revealed an admitted [DATE] with diagnoses including anoxic brain damage, chronic respiratory failure, encephalopathy, epilepsy, tracheostomy status, gastrostomy status, persistent vegetative state and multiple sclerosis. Review of Resident #1's medication administration record (MAR) from January 2025 indicated an order dated 11/08/24 for valproic acid 250 milligrams (mg) per five milliliters (ml), give ten ml enterally four times daily for seizures at early (6:00 A.M. to 10:00 A.M.), noon (11:00 A.M. to 2:00 P.M.), PM (3:00 P.M. to 7:00 P.M.) and HS (8:00 P.M. to 12:00 A.M.). Review of Resident #1's MAR from January 2024 and medication administration audit report (MAAR) from 01/13/25 to 01/19/25 for valproic acid revealed on 01/14/25, the noon dose was not administered until 5:43 P.M. On 01/16/25, the noon dose was not administered until 3:34 P.M. On 01/17/25, the noon dose and PM dose were not administered as ordered. On 01/18/25, the noon dose was not administered until 3:20 P.M. and the PM dose was administered at the same time as the noon dose at 3:20 P.M. Review of Resident #1's MAR from January 2025 indicated an order dated 11/08/24 for guaifenesin 400 mg enterally four times daily for secretions at early, noon, PM and HS. Review of Resident #1's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for guaifenesin revealed on 01/14/25, the noon dose was not administered until 5:43 P.M. On 01/16/25, the noon dose was not administered until 3:34 P.M. On 01/17/25, the noon dose and PM dose were not administered as ordered. On 01/18/25, the noon dose was not administered until 3:20 P.M., and the PM dose was administered at the same time as the noon dose at 3:20 P.M. Review of Resident #1's MAR from January 2025 indicated an order dated 12/04/24 for baclofen 20 mg enterally four times daily for muscle spasms at early, noon, PM and HS. Review of Resident #1's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for baclofen revealed on 01/14/25, the noon dose was not administered until 5:43 P.M. On 01/16/25, the noon dose was not administered until 3:34 P.M. On 01/17/25, the noon dose and PM dose were not administered as ordered. On 01/18/25, the noon dose was not administered until 3:20 P.M. and the PM dose was administered at the same time as the noon dose at 3:20 P.M. Review of Resident #1's MAR from January 2025 indicated an order dated 11/08/24 for gabapentin 600 mg enterally three times daily for neuropathy at early, noon, and HS. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Autumn Hills Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2565 Niles Vienna Rd Niles, OH 44446	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for gabapentin revealed on 01/14/25, the noon dose was not administered until 5:43 P.M. On 01/16/25, the noon dose was not administered until 3:34 P.M. On 01/17/25, the noon dose was not administered as ordered. On 01/18/25, the noon dose was not administered until 3:20 P.M. Interview on 01/23/25 at 8:14 A.M. with Director of Nursing (DON) verified the above medication administration findings. 2. Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included anoxic brain damage, chronic respiratory failure, quadriplegia, tracheostomy status, gastrostomy status, epilepsy, encephalopathy, persistent vegetative state and lumbar intervertebral disc degeneration. Review of Resident #27's MAR from January 2025 indicated an order dated 12/23/24 for pregabalin 150 mg enterally three times daily for lumbar intervertebral disc degeneration at early, noon and HS. Review of Resident #27's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for pregabalin revealed on 01/14/25, the noon dose was not administered until 5:45 P.M. On 01/15/25, the noon dose was not administered until 4:03 P.M. On 01/16/25, the noon dose was not administered until 3:35 P.M. On 01/17/25, the noon dose was not administered as ordered. On 01/18/25, the noon dose was not administered until 3:21 P.M. On 01/19/25, the noon dose was not administered until 3:15 P.M. Review of Resident #27's MAR from January 2025 indicated an order dated 12/23/24 for valproic acid 500 mg per ten ml and give 15 ml enterally three times daily for epilepsy at early, noon and HS. Review of Resident #27's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for valproic acid revealed on 01/14/25, the noon dose was not administered until 5:45 P.M. On 01/15/25, the noon dose was not administered until 4:04 P.M. On 01/16/25, the noon dose was not administered until 3:35 P.M. On 01/17/25, the noon dose was not administered as ordered. On 01/18/25, the noon dose was not administered until 3:21 P.M. On 01/19/25, the noon dose was not administered until 3:15 P.M. Interview on 01/23/25 at 8:14 A.M. with DON verified the above medication administration findings. 3. Review of the medical record for Resident #27 revealed an admitted [DATE]. Diagnoses included anoxic brain damage, chronic respiratory failure, quadriplegia, tracheostomy status, gastrostomy status, epilepsy, encephalopathy, persistent vegetative state and lumbar intervertebral disc degeneration. Interview on 01/22/25 at 4:49 P.M. with power of attorney (POA) for Resident #27 complained the facility had just informed that Resident #27 was started on Synthroid for hypothyroidism, but over one month ago, they had already received notification the medication was supposedly started. Additional medical record review for Resident #27 revealed a diagnosis of hypothyroidism was added on 01/22/25. Review of the laboratory testing for TSH (thyroid-stimulating hormone) for Resident #27 was completed on 12/05/24 with an abnormally high result of 19.6 with a normal range value expected between 0.34 to 5.5. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the nurse practitioner progress note dated 12/10/24 indicated Resident #27 was examined for follow-up. Labs indicated an elevated TSH level. Add Synthroid 25 micrograms (mcg) daily and recheck TSH in four weeks. POA for Resident #27 made aware. Review of the plan of care initiated 12/11/24 revealed Resident #27 had hypothyroidism and received medication for management. Interventions included administering medication as ordered and monitoring laboratory values. Review of Resident #27's physician orders for December 2024 revealed on 12/04/24 a repeat TSH level was to be completed in three months. There was no order for the medication Synthroid. Review of nurse practitioner progress notes dated 12/16/24, 12/27/24 and 01/03/25 indicated Resident #27's MAR and labs were reviewed but there was no documentation related to Resident #27's hypothyroidism or Synthroid use. Review of nurse practitioner progress note dated 01/22/25 revealed Resident #27 was examined for follow-up. Resident #27 had hypothyroidism with intervention of Synthroid 25 mcg and recheck TSH level in four weeks. Review of Resident #27's physician orders from December 2024 to January 2025 revealed the medication Synthroid was not initiated until 01/22/25 for 25 mcg enterally every morning for hypothyroidism. Review of Resident #27's MAR from December 2024 to January 2025 revealed Synthroid was not ordered or administered until 01/22/25. Interview on 01/23/25 at 7:54 A.M. with DON and Administrator verified the above findings and confirmed when Resident #27's medical record was audited by the facility on 01/22/25, an error was discovered. Resident #27's medication, Synthroid, was not initiated in December 2024 as directed by the nurse practitioner. 4. Review of the medical record for Resident #86 revealed an admitted [DATE]. Diagnoses included chronic obstructive pulmonary disease, diabetes mellitus type two with neuropathy, chronic respiratory failure, tracheostomy status, disturbances of salivary secretion, gastrostomy status, essential primary hypertension and depression. Interview on 01/21/25 at 8:05 A.M. with Resident #86 complained about a recent confrontation with Licensed Practical Nurse (LPN) #287 who when questioned about her medication schedule, responded rudely and thereafter retaliated by ignoring Resident #86, giving all other residents medications first before administering hers, making them late. Review of Resident #86's MAR from January 2025 indicated an order dated 01/15/25 for midodrine five mg enterally three times daily for hypotension at early, noon and HS. Review of Resident #86's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for midodrine revealed on 01/15/25, the noon dose was not administered until 5:20 P.M. On 01/16/25, the noon dose was not administered until 3:35 P.M. On 01/18/25, the noon dose was not administered until 3:21 P.M. On 01/19/25, the noon dose was not administered until 3:14 P.M. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #86's MAR from January 2025 indicated an order dated 01/15/25 for Vistaril 50 mg enterally three times daily for anxiety at early, noon and HS. Review of Resident #86's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for Vistaril revealed on 01/16/25, the noon dose was not administered until 3:35 P.M. On 01/18/25, the noon dose was not administered until 3:21 P.M. On 01/19/25, the noon dose was not administered until 3:14 P.M. Review of Resident #86's MAR from January 2025 indicated an order dated 01/15/25 for gabapentin 300 mg enterally three times daily for difficulty in walking at early, noon and HS. Review of Resident #86's MAR from January 2024 and MAAR from 01/13/25 to 01/19/25 for gabapentin revealed on 01/16/25, the noon dose was not administered until 3:35 P.M. On 01/18/25, the noon dose was not administered until 3:21 P.M. On 01/19/25, the noon dose was not administered until 3:14 P.M. Interview on 01/23/25 at 8:14 A.M. with DON verified the above medication administration findings. Review of the facility policy, Medication Administration Schedule, dated July 2016 revealed early was a routine schedule of 6:00 A.M. to 10:00 A.M., noon was 11:00 A.M. to 2:00 P.M., PM was 3:00 P.M. to 7:00 P.M. and HS was 8:00 P.M. to 12:00 A.M Review of the undated facility policy, Medication Administration - General Guidelines revealed medications were administered within 60 minutes of scheduled time and the individual who administered the medication dose recorded the administration on the electronic MAR directly after the medication was given. At the end of each medication pass, the person administering medications reviewed the electronic MAR to ensure necessary doses were administered and documented. In no case should an individual who administered medications report off-duty without first recording the administration of any medications. This deficiency represents non-compliance investigated under Master Complaint Number OH00161540.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on record review, interview and facility policy review, the facility failed to ensure Resident #27's medical records were accurate and did not contain false information. This affected one resident (#27) out of 12 medical records reviewed for accuracy of medical record. The facility census was 106. Findings include: Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including anoxic brain damage, chronic respiratory failure, quadriplegia, and persistent vegetative state. Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #27 had impaired cognition. He was dependent on staff for all activities of daily living (ADL) including rolling left and right, toileting hygiene, personal hygiene, transfers, and showers. He was always incontinent with bowel and bladder. He was at risk for developing pressure ulcers but had no unhealed pressure ulcers on admission. Review of the Skin Grid Pressure 3.0-V2 dated 12/19/24 and completed by Wound Nurse/Licensed Practical Nurse (LPN) #209 revealed on 12/18/24, Resident #27 was identified to have a new Stage three (full thickness tissue loss, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, slough may be present but does not obscure the depth of tissue loss, may include undermining and tunneling) pressure ulcer to his sacrum area that measured a length of 5.5 centimeter (cm), width of 6.1 cm and depth of 0.3 cm. The assessment described the area as: several open areas across the sacrum among scar tissue from a previously healed pressure wound. There was thin slough with granulating tissue with scattered areas of moist tissue at wound edges. The wound had moderate drainage. Review of the facility form labeled Unavoidable Pressure Injury dated 12/19/24 revealed Resident #27's pressure ulcer was unavoidable because the resident had impaired mobility, bowel incontinence, quadriplegia and had a prior history of pressure ulcer in the same location. The form had a line for the physician signature: Nurse Practitioner (NP) #317's name was printed on the physician's signature line. Interview on 01/22/25 at 9:42 A.M. with NP #317 regarding the facility form labeled Unavoidable Pressure Injury dated 12/19/24 revealed Resident #27's pressure ulcer was unavoidable because the resident had impaired mobility, bowel incontinence, quadriplegia and had a prior history of pressure ulcer in the same location. The form had a line for the physician signature: Nurse Practitioner (NP) #317's name was printed on the physician's signature line. She revealed she had never seen this form prior and verified she had not filled out this form. She never discussed Resident #27's wound with the facility. She revealed she did not get involved with the wounds because the facility had a wound company that came in and handled the wounds at the facility. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/22/25 at 10:45 A.M. with Director of Nursing (DON) revealed she was not aware Wound Nurse/LPN #209 had printed NP #317's name on the form in the area of physician signature. She verified she had spoken with NP #317 who also confirmed to her that she had not signed the form and/or had any discussion with the facility regarding Resident #27's wound status. She revealed she felt it was a mistake but could not speak about why this was done at this time as currently Wound Nurse/LPN #209 was on suspension. She verified Resident #27's medical record was not accurate. Review of the undated facility policy labeled, Documentation revealed the resident's clinical record was to be a concise account of treatment, care, response of care, signs, symptoms, and progress of the resident's condition. There was nothing in the policy regarding ensuring records did not contain falsified information including placing a physician/NP name on a signature line on a form without discussing the situation with them and/or obtaining permission to their name on the form/assessment. This deficiency represents non-compliance investigated under Complaint Number OH00161212.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39973 Based on observation, interview, record review, review of video recordings provided by Resident #27's fiancee/power of attorney (POA), review of center for Medicare and Medicaid Services (CMS) and Health and Human Services (HHS) memorandum QSO-24-08-NH and facility policy review, the facility did not ensure proper infection control measures were followed including during wound care and donning enhanced barriers precautions (EBP) during care for Resident #27. This affected one resident (#27) out of three residents reviewed for wound care and EBP. This had the potential to affect seven additional residents identified by the facility with wounds (#22, #62, #70, #80, #88, #102, and #109) and 27 residents (#1, #5, #9, #10, #16, #18, #20, #23, #39, #42, #48, #52, #53, #67, #69, #78, #80, #81, #84, #86, #87, #93, #97, #100, #101, #102, and #107) identified by the facility on EBP. The facility census was 106. Findings include: Review of the medical record for Resident #27 revealed an admitted [DATE] with diagnoses including anoxic brain damage, chronic respiratory failure, quadriplegia, and persistent vegetative state. Review of the December 2024 and January 2025 physician's orders revealed Resident #27 had the following orders: suction as needed, dated 12/04/24; tracheostomy care every shift and as needed, dated 12/04/24; Jevity (enteral tube feeding) 1.5 60 milliliters (ml) per hour continuous per peg tube, dated 12/05/24; cleanse percutaneous endoscopic gastrostomy (PEG) tube (a feeding tube that is surgically placed into the stomach through the abdomen) site with soap and water daily, dated 12/05/24; assess tracheostomy stoma every shift and as needed, dated 12/08/24; cleanse with normal saline, apply Medi honey (honey based product for wound care) and calcium alginate (water soluble wound care product to manage moderate to heavy drainage) and cover with foam dressing every shift, dated 12/19/24; cleanse sacrum with normal saline and apply calcium alginate and cover with foam dressing, dated 01/02/25. The physician orders revealed EBP due to tracheostomy and PEG tube were not ordered until 01/22/25 after brought to facility attention that they did not have an order. Review of the care plan dated 12/05/24 revealed Resident #27 was dependent on staff with activities of daily living (ADL) due to anoxic brain damage and persistent vegetative state. Interventions included turning and repositioning every two hours, staff to provide incontinence care with routine rounds, and staff to provide all care as he was dependent and did not participate in any aspect of his ADL care. There was nothing in the care plan regarding EBP during ADL care. Review of the care plan dated 12/05/24 revealed Resident #27 was at risk for impaired skin integrity secondary to bowel and bladder incontinence and impaired mobility. He required total staff dependence for all his care needs. Interventions included elevating heels off mattress, inspecting skin during routine daily care, lift sheet on chair/bed for positioning, lotion to skin as needed, incontinence care after each incontinent episode, pressure reduction mattress to bed, and treatments as ordered. There was nothing in the care plan regarding EBP during his wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the care plan dated 12/05/24 revealed Resident #27 had an alteration in respiratory function related to respiratory failure. He had a tracheostomy with continuous oxygen. He was unable to clear secretions himself and required suctioning. Interventions included checking oxygen saturation levels every shift, elevating the head of the bed, evaluating for shortness of breath, and respiratory treatments as needed. There was nothing in the care plan regarding EBP. Review of the undated video recording provided by Resident #27's fiancee/ POA revealed Licensed Practical Nurse (LPN) #214 and Certified Nursing Assistant (CNA) #201 were in Resident #27's room providing the following care with a mask, gloves and without a gown: They rolled Resident #27 towards LPN #214 as Resident #27 was in direct contact with both their uniform tops. LPN #214 moved his catheter bag and oxygen support that was hooked to his tracheostomy. CNA #201 then proceeded to provide incontinence care and provide a full bed linen change. They then provided to roll Resident #27 towards CNA #201 as LPN #201 completed his incontinence care and changing of linen. During the care, Resident #27 was completely dependent on staff as he was in a persistent vegetative state. It was visible in the video that Resident #27 was connected to enteral feeding per PEGtube and had a tracheostomy. Review of the video recording dated 01/14/25 at 2:22 P.M. and provided by Resident #27's fiancee/POA revealed Wound Nurse/LPN #209 and LPN #287 were in Resident #27's room observed rolling Resident #27 towards the door as he was dependent on staff with bed mobility. Wound Nurse/LPN #209 and LPN #287 both were only wearing gloves but no other EBP including gowns. Wound Nurse/LPN #209 then proceeded to remove the dressing to his sacrum area. She proceeded to cleanse the area and apply a new dressing without performing hand hygiene after she removed the old dressing. Interview on 01/21/25 at 10:08 A.M. and 01/22/25 at 4:49 P.M. with Resident #27's fiancee/POA verified she took the video on 01/14/25 at 2:22 P.M. and acknowledged that staff were not wearing gowns when providing care for Resident #27 as well as Wound Nurse/LPN #209 changed his dressing without washing her hands throughout the process. She revealed the other video she did not have the exact date of when the video was taken but within the last two weeks and acknowledged that staff were not wearing gowns. She revealed she never witnessed staff wearing gowns in any of the videos or when she was present at the facility as she did not know that was a requirement. She revealed today, 01/21/25 when she observed everyone entering his room with a gown that she thought he must have been diagnosed with COVID-19 but instead she found out that they were wearing the gowns because a surveyor was in the building which she did not feel was right. Observation with the Director of Nursing (DON) on 01/21/24 at 2:22 P.M. and 2:44 P.M. of video recording dated 01/14/24 at 2:22 P.M. revealed Wound Nurse/LPN #209 and LPN #287 were rolling Resident #27 over and Wound Nurse/LPN #209 performed wound care. She verified that both Wound Nurse/LPN #209 and LPN #287 were not wearing gowns as indicated for EBP since Resident #27 had a pressure ulcer, tracheostomy, and PEG tube site. The DON also verified Wound Nurse/LPN #209 had performed wound care without performing hand hygiene after she had removed the old dressing on Resident #27's sacrum. The DON also observed the undated video that showed LPN #214 and CNA #201 in Resident #27's room completing direct care including turning Resident #27 and providing incontinence care without a gown in place. The DON verified Resident #27 was to be on EBP, and they should have utilized a gown during his care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 01/21/25 at 3:20 P.M. with Wound Nurse/LPN #209 observed the video recording dated 01/14/24 at 2:22 P.M. and verified that she was not wearing EBP when she changed Resident #27's wound dressing including a gown. She also verified she had removed the old dressing to his sacrum area, cleansed the area, and applied a new treatment without performing hand hygiene. She verified she should have washed her hands after removing the old dressing. Interview on 01/23/25 at 8:47 A.M. with CNA #201 revealed he most likely was not wearing a gown during the undated video. He revealed he never wore a gown when he entered Resident #27's room as he did not know he needed to. He revealed he had seen nurses several times in Resident #27's room, and that they never had a gown on, so he assumed it was not required. He revealed he was not sure what EBP were and/or which residents required this precaution. Interview on 01/23/25 at 10:20 A.M. with LPN #287 stated if it was on the video that she was not wearing a gown for Resident #27's care, she was most likely not wearing one. She revealed she never received detailed training on what EBP were. Review of the facility policy labeled, Enhanced Barrier Precautions, dated March 2024, revealed the purpose of the policy was to reduce the transmission of multi resistant organism (MDRO) when high contact resident care activities for residents with known to be colonized or infected with MDRO as well as those at increased risk to acquire MDRO. The policy revealed residents with the following triggers would receive EBP including residents with wounds, and/or indwelling medical devices. Indwelling medical devices include feeding tubes and tracheostomies. The policy revealed high contact resident care activities requiring gown and glove use included providing hygiene, changing briefs, assisting with toileting, and device care. Review of the CMS and HHS memorandum, QSO-24-08-NH, entitled Enhanced Barrier Precautions in Nursing Homes, dated 03/20/24, by the Centers for Medicare & Medicaid Services, Department of Health & Human Services revealed EBP are indicated for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO. The effective date for implementation of enhanced barrier precautions under the guidelines was 04/01/24. Review of the undated facility policy, Pressure Ulcer Prevention Intervention revealed cleanse with normal saline, portable water or with surfactants that have antimicrobial agents for suspected infection. There were no step-by-step guidelines in regard to during wound care when hands were to be washed. Review of the undated facility procedure labeled, Dressing Change- Clean revealed the purpose was to provide guidelines for proper application of dressing. The procedure revealed the nurse was to wash and dry her hands thoroughly before starting a dressing change and apply gloves. The nurse was to remove the dressing and discard and then wash her hands. This deficiency represents non-compliance investigated under Master Complaint Number OH00161540 and Focused Infection Control Survey.