| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 365672 | A. Building<br>B. Wing | 03/06/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Autumn Hills Care Center | 2565 Niles Vienna Rd<br>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) |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565<br><br>Based on record review, interview and policy review, the facility failed to timely notify a family member of a medication change for Resident #108. This affected one resident (#108) of ten residents reviewed for family notification of a change. The facility census was 106.<br><br>Findings include:<br><br>Review of the medical record for Resident #108 revealed an admitted [DATE]. Significant diagnoses included acute and chronic respiratory failure, dependence on a respirator, chronic obstructive pulmonary disease, Wernicke's encephalopathy and alcohol use with withdrawal and delirium The resident face sheet revealed Resident #108 had a Healthcare Power of Attorney (POA) listing his sister. A second sister was listed as POA should the first not be able to carry out the duties. Both sisters had phone numbers on the resident face sheet.<br><br>Further review of the medical record revealed Resident #108 had a drug allergy (an immune system overreaction to a substance that is usually harmless to most people) to Depakote (a medication used for mood stabilization).<br><br>Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #108 was cognitively impaired.<br><br>Review of physician orders for Resident #108 revealed on 01/24/25 at 10:52 A.M. Depakote 125 milligrams (mg) two times a day was ordered and on 01/24/25 at 6:36 P.M. Depakote 125 mg three times a day was ordered and the order for Depakote 125 milligrams two times daily was discontinued.<br><br>A review of the Medication Administration Record (MAR) dated 01/01/25 to 01/31/25 revealed Depakote was listed as an allergy. The MAR also revealed Resident #108 received Depakote 125 milligrams on 01/24/25 at bedtime, 01/25/26 in the morning, noon and bedtime and 01/26/25 in the morning and at noon.<br><br>A review of progress notes dated 01/24/25 at 12:59 P.M. and authored by Psychiatric Nurse Practitioner #317 revealed an allergy to valproic acid (generic name for Depakote). The note also revealed an order to discontinue Depakote 125 milligrams two times daily and start Depakote 125 milligrams three times daily.<br><br>(continued on next page) |

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

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

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of progress notes dated 01/24/25 to 01/25/25 revealed the sisters of Resident #108 were not informed of the addition of Depakote to the medication regimen.<br><br>A review of a care plan dated 01/29/25 revealed an alteration in cognitive function secondary to alcohol abuse. Interventions included keep in close contact with the responsible party. The care plan also revealed Resident #108 was at risk for complications secondary to allergy/medication use dated 01/27/25. Interventions included administer medications as ordered, notify the doctor as indicated, observe and monitor for symptoms of adverse reactions hives, difficulty breathing, swelling in the face or throat, severe skin reaction with fever, sore throat, burning eyes, skin pain, red or purple skin rash with blistering and peeling, obtain and monitor labs per order, obtain and monitor vital signs per order and as indicated.<br><br>On 02/25/25 at 4:05 P.M. an interview with the Director of Nursing (DON) verified the POAs for Resident #108 were not notified of the addition of Depakote to the medication regimen. The DON also stated responsible parties are to be notified of medication changes.<br><br>On 02/26/25 at 8:30 A.M. an interview with the sister of Resident #108 revealed they were not notified of the addition of Depakote to the medication regimen. The sister further stated had she been notified Resident #108 would not have received the Depakote.<br><br>On 03/03/24 at 11:25 A.M. an interview with Psychiatric Nurse Practitioner (PNP) #317 revealed they had written the order for Depakote on 01/24/25. PNP #317 also stated the facility notifies family members of changes to medications. PNP #317 confirmed they had not notified the family of the Depakote order.<br><br>A review of the policy titled Status Change in Resident Condition/Notification, undated, revealed the facility of Continuing Healthcare Solutions will promptly notify the resident, his or her attending physician and responsible party of changes in the resident condition and or status change.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00163033, OH00162671 and OH00162547. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48565<br><br>Based on record review, interviews and policy review, the facility failed to collaborate with pharmacy services to ensure a medication listed as a drug allergy was not dispensed and administered to Resident #108 until determined to be safe for Resident #108 to receive the medication. This affected one resident (Resident #108) of ten residents who were reviewed for medication administration. The facility census was 106.<br><br>Findings include:<br><br>Review of the medical record for Resident #108 revealed an admitted [DATE] with diagnoses including acute and chronic respiratory failure, dependence on a respirator, chronic obstructive pulmonary disease, Wernicke's encephalopathy, and alcohol use with withdrawal and delirium. The medical record indicated Resident #108 had a drug allergy (an immune system overreaction to a substance that is usually harmless to most people) to Depakote (a medication used for mood stabilization).<br><br>Review of the records from a hospital emergency room visit prior to admission to the facility, dated 12/16/24, revealed these records were provided to the facility as a referral packet dated 12/30/24 and indicated divalproex sodium (Depakote) was listed as an adverse reaction. (an adverse reaction to a medication is an unwanted, undesirable effect possibly related to medication usage).<br><br>Review of the admission Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed Resident #108 was cognitively impaired.<br><br>Review of physician orders for Resident #108 revealed on 01/24/25 at 10:52 A.M. Depakote 125 milligrams (mg) two times a day was ordered and on 01/24/25 at 6:36 P.M. Depakote 125 mg three times a day was ordered and the order for Depakote 125 milligrams two times daily was discontinued.<br><br>Review of progress notes dated 01/24/25 at 12:59 P.M. and authored by Psychiatric Nurse Practitioner (PNP) #317 revealed Resident #108 had an allergy to valproic acid (generic name for Depakote). The note further revealed Resident #108 reported with unstable mood and behaviors. Resident #108 was showing an allergy to Valproic acid, however was currently on Depakote two times daily and was doing well with no symptoms of allergies or adverse reactions. The note also revealed an order to discontinue Depakote 125 milligrams two times daily and start Depakote 125 milligrams three times daily.<br><br>Review of the Medication Administration Record (MAR) dated 01/01/25 to 01/31/25 revealed Depakote was documented as an allergy. The MAR also revealed Resident #108 received Depakote 125 milligrams on 01/24/25 at bedtime, 01/25/26 in the morning, noon and bedtime and 01/26/25 in the morning and at noon.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of progress notes dated 01/16/25 through 01/25/25 showed no evidence the facility had contacted the primary care physician, nurse practitioner, or pharmacy to discuss the listed drug allergy to Depakote and if it would have been safe to administer the medication despite the listed allergy of Resident #108. Further review of the progress notes dated 01/16/25 through 01/25/25 showed no evidence the facility contacted the family to determine why Depakote was listed as an allergy and what reactions Resident #108 had to Depakote to determine safety of medication administration.<br><br>Review of a progress note dated 01/26/25 at 1:57 P.M. and authored by Licensed Practical Nurse (LPN) #238 revealed the doctor was notified of a family concern related to adverse reactions to divalproex (Depakote) in the past for Resident #108. A new order to hold the medication was obtained and to consult the physician from the psychiatric care provider. The medication was placed on hold, and the family was made aware of the action taken.<br><br>Review of a physician order dated 01/26/25 for Resident #108 revealed the Depakote 125 mg three times a day was discontinued.<br><br>Review of the care plan dated 01/29/25 revealed Resident #108 was at risk for complications secondary to allergy/medication use. The Physician/Certified Nurse Practitioner (CNP) were notified of the medication allergy and dose the resident received with new orders noted. The family was made aware of the above dated 01/27/25. Interventions included to administer medications as ordered, notify the doctor as indicated, observe and monitor for symptoms of adverse reactions such as hives, difficulty breathing, swelling in the face or throat, severe skin reaction with fever, sore throat, burning eyes, skin pain, red or purple skin rash with blistering and peeling; obtain and monitor labs per order, obtain and monitor vital signs per order and as indicated. There was no specific drug identified by name on the care plan. There were no prior entries on the care plan to identify any drug allergies or drug intolerances for Resident #108 prior to the 01/29/25 entry on the care plan.<br><br>A review of an email dated 01/30/25 at 10:19 A.M. from Pharmacist #319 revealed he was notified of the incident of Depakote being sent to the facility for Resident #108. The email further acknowledged Depakote being on file as an allergy at the pharmacy, but it got missed when they verified the order. Pharmacist #319 then went on to state the pharmacy should have caught the allergy for Depakote for Resident #108.<br><br>On 02/25/24 at 4:05 P.M. an interview with the Director of Nursing (DON) revealed Resident #108 received six doses of Depakote and had no ill effects. The DON stated Depakote was listed as an intolerance in Resident #108's medical records. However, the DON then verified if a medication was listed as an allergy it should have been questioned by the nurse transcribing the order and the pharmacist processing the order and sending the medication. The DON further stated the medication should not have been sent by the pharmacist without notifying the facility so a clarification of the order could be obtained.<br><br>On 02/26/25 at 8:30 A.M. an interview with the sister of Resident #108 revealed they were not notified of the addition of Depakote to the medication regimen. The sister also stated Depakote caused her brother to become very lethargic. The sister further stated had she been notified Resident #108 would not have received the Depakote.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 02/26/25 at 1:14 P.M. an interview with Pharmacist #319 revealed when new orders were received a drug utilization review (DUR) was done electronically. The DUR detects duplicate orders, drug interactions and allergies. Pharmacist #319 also stated the dispensing pharmacist was to review anything on the DUR prior to dispensing medications and contact the facility via fax or phone call regarding any issues. Pharmacist #319 stated the pharmacy should have caught the allergy to Depakote for Resident #108 and not dispensed the medication for resident use.<br><br>On 03/03/25 at 11:25 A.M. an interview with PNP #317 revealed she prescribed Depakote due to Resident #108 exhibiting agitation and verbal aggression and he had been on Depakote at other facilities. PNP #317 stated Resident #108 was not allergic to Depakote, but he was intolerant of it. PNP #317 confirmed she had increased the dosage of the Depakote from 125 mg twice a day to 125 mg three times a day. PNP #317 confirmed she had not discussed the order for Depakote with the family because the facility was responsible for notifying the family of any medication changes and the facility should have contacted the family.<br><br>A review of the document titled Pharmacy Services Agreement, dated 07/31/24, revealed the pharmacy will promptly fill orders from the customer and deliver to the customer's prescription and non prescription drugs biologicals and intravenous solutions, supplies and equipment and services as set forth in this agreement. The contract also stated the pharmacy will have a licensed pharmacist available 24 hours each day seven days a week to respond to customer request for pharmacist consultation.<br><br>A review of the document titled Consultant Pharmacist, dated January 2016, revealed the pharmacist provides clinical expertise by responding to medication related questions and concerns. The document also revealed the pharmacists will maintain a strong knowledge of current clinical pharmacy practices. The document further stated the pharmacist will conduct job responsibilities accordance with standards set forth with applicable federal and state laws and applicable professional standards.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00163033. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>48565<br><br>Based on observation, interview and policy review, the facility failed to maintain a sanitary environment for all residents. This affected six Residents (#14, #18, #26, #37, #76 and #86) of 17 residents reviewed for physical environment and had the potential to affect all residents in the facility. The facility census was 106.<br><br>Findings include:<br><br>Observation was conducted on 02/24/25 at 9:50 A.M. with the Assistant Director of Nursing (ADON) of the general facility environment including resident rooms and common areas throughout the facility. At the time of the observations, the ADON verified the following identified concerns:<br><br>In the main lobby, there was a drinking fountain with a moderate build-up of dust on the top of it. The lobby floor was noted to be only partially clean, as there were were mop swirls noted on the floor that stopped at the floor mats. There was white dust build-up between the floor mats. Footprints were noted within the dust build up. A visitor sign located in the lobby had white dust build-up on the base of the stand.<br><br>The main dining room floor was noted to have visible dirt throughout the room and there was a large blackened area on the floor approximately 20 feet into the door going towards the left of the room. A small dining table located next to the exit door on the left-hand side of the room was noted to have a dust buildup on it. The piano located on the back wall was noted to have a dust buildup on the top of it.<br><br>In the room of Resident #76, there was a build-up of black dirt on the floor at the foot of the bed, dead flower petals on the floor at the head of the bed and dirt build-up and cobwebs were noted behind the door.<br><br>In the room of Resident #14 and Resident #18, the floor was noted to have food crumbs and three paperclips located under the unoccupied wheelchair of Resident #14. The right-hand side bedrail for Resident #14 was noted to have dried food on the lower right-hand side of the rail. An interview with Resident #14 at the time of the observation revealed staff does not clean the rail.<br><br>A Hoyer lift (a mechanical lift used for residents who cannot stand to transfer) was noted in the 200 hall with visible dirt on the base of the devise.<br><br>The shower room on the 200 hall was noted to have hair and soap scum build-up on the drain located in the middle of stall one. Hair and soap scum was also noted on the drain located in the center of stall two. There was an orange, slimy build-up noted on the white tiles of shower stall two under the shower head and handle. There was a black build-up in the grout of the white tile located on the wall opposite the shower head and handle. The floor in the shower room was noted to be dirty with build up of visible dirt around the garbage can.<br><br>(continued on next page) |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | In the room of Resident #26 and Resident #86, there was dirt on the floor with a build-up of dirt and dust behind the door.<br><br>In the room of Resident #37, the floor was dirty and there was a build-up of dirt behind the door.<br><br>On 02/27/25 at 1:20 P.M. an interview with Housekeeping Supervisor (HKS) #320 revealed resident rooms were to be cleaned daily including toilets, sinks and floors. Resident rooms were to be mopped daily including behind the doors. Shower rooms were cleaned weekly by HKS #320. HKS #320 also stated the acrylic caulking in the shower room on the 200 unit would quickly grow mildew and the shower handle in stall two was leaking for a couple weeks lending to the orange buildup on the walls. Items on bedside tables and any shelving units were to be moved and dusted thoroughly two times weekly.<br><br>A review of the policy titled Housekeeping Policy /Procedure, undated, revealed the facility will be maintained and cleaned to meet a homelike environment.<br><br>This deficiency represents non-compliance investigated under Complaint Number OH00161937. |