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	06/05/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and review of the facility shower schedules, the facility failed to provide showers as scheduled to Residents #23, #25, #31, and #53. This affected four (Residents #23, #25, #31, and #53) of seven residents reviewed for showers. The facility census was 99. Findings include: 1. Review of the medical record for Resident #23 revealed an admission date of 07/05/25. Diagnoses included type two diabetes mellitus, acute respiratory failure, and morbid obesity. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #23 had intact cognition. Resident #23 required moderate to extensive assistance for all activities of daily living. Review of the care plan dated 05/27/25 revealed Resident #23 required assistance with activities of daily living secondary to decreased mobility, generalized muscle weakness, and shortness of breath. Interventions included for staff to provide assistance with daily hygiene and showering per facility policy. Review of the facility shower schedule revealed Resident #23 was scheduled showers every Wednesday and Friday. Review of the shower sheets and shower documentation for Resident #23 for May 2025 revealed she did not have documentation of receiving a shower or refusal or shower on 05/16/25. 2. Review of the medical record for Resident #25 revealed an admission date of 01/04/10. Diagnoses included motor neuron disease, type two diabetes mellitus, and chronic obstructive pulmonary disease. Review of the quarterly MDS assessment dated [DATE] revealed Resident #25 had intact cognition. Resident #25 required extensive assistance to complete dependence on staff for all activities of daily living. Review of the care plan dated 05/29/25 revealed Resident #25 required activities of daily living assistance secondary to impaired mobility and generalized muscle weakness. Interventions included that Resident #25 was totally dependent on staff for showers, and for staff to assist with daily hygiene needs. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the shower schedule revealed she was to have showers every Monday, Wednesday, and Friday. Review of the shower sheets for Resident #25 for May 2025 revealed she did not have documentation of receiving a shower or refusal or shower on 05/09/25 or 05/26/25. Interview on 06/03/25 at 8:23 A.M. with Resident #25 reported she is not getting three showers a week like she is scheduled. She reported she is lucky if she gets two a week. 3. Review of the medical record for Resident #31 revealed an admission date of 03/28/25. Diagnoses included malignant neoplasm of the cerebrum with metastasis, epilepsy, and hypertension. Review of the care plan dated 03/28/25 revealed Resident #31 required assistance from staff for activities of daily living. Interventions included that staff would assist with daily hygiene and showers as per facility policy. Review of the admission MDS assessment dated [DATE] revealed Resident #31 had moderate cognitive impairment. Resident #31 required set-up to moderate assistance for all activities of daily living. Review of the shower schedule revealed he was to be showered on Sundays and Thursdays. Resident #31 did not receive showers on 05/01/25, 05/04/25, 05/11/25, 05/15/25, and 05/18/25 with no documented evidence of refusals. 4. Review of the medical record for Resident #53 revealed an admission date of 08/26/24. Diagnoses included Huntington's disease and dysphagia. Review of the quarterly MDS assessment dated [DATE] revealed Resident #53 had moderate cognitive impairment. Resident #53 required extensive assistance to total dependence on staff for all activities of daily living. Review of the care plan dated 05/26/25 revealed Resident #53 required assistance from staff for activities of daily living. Interventions included that staff would assist with daily hygiene and showers as per facility policy. Review of the shower sheets for May 2025 revealed she was ordered showers every Monday, Wednesday, and Friday. Review of the shower sheets for May 2025 for Resident #53 revealed she did not have documentation of receiving a shower or refusal or shower on 05/09/25. Interview on 06/04/25 at 9:48 A.M. with the Administrator confirmed that showers have been an issue in the facility and verified the missing showers for Residents #23, #25, #31, and #53. The Administrator reported they changed the system with showers in February 2025 with getting rid of the shower aide, and the facility has struggled since. This deficiency represents non-compliance investigated under Complaint Number OH00166091.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and facility policy review, the facility failed to adequately control Resident #38's pain when his as needed pain medication was not administered timely on 05/31/25. This affected one (Resident #38) of three residents reviewed for pain management. The facility census was 99. Findings include: Review of the medical record for Resident #38 revealed an admission date of 05/29/25. Diagnoses included sepsis, fracture of the left pubis, and wedge compression fracture of the third lumbar vertebra. Review of the physician's order dated 05/29/25 revealed an order to administer oxycodone (opioid pain medication) 10 milligrams (mg) by mouth every four hours as needed for pain. Review of the admission assessment dated [DATE] revealed Resident #38 had intact cognition and was aware of person, place, and time. Resident #38 reported he had severe pain. Review of the care plan dated 05/29/25 revealed Resident #38 was at risk for alteration in comfort secondary to bacteremia infection, closed compression fractures, and left-sided inferior pubic ramus closed fracture. Interventions included administering medications as ordered and monitoring for effectiveness and interventions. Review of the Medication Administration Record (MAR) for 05/31/25 revealed Resident #38 received his oxycodone at 4:02 A.M. and did not receive his next dose until 10:49 A.M. Interview on 06/03/25 at 8:43 A.M. with Resident #38 reported he keeps notes on everything. Review of the progress notes on 05/31/25 revealed he activated his call button from 8:30 A.M. to 9:30 A.M. His call light still had not been answered, so he called the main phone line reporting he wanted pain medication because it was due at 8:30 A.M., and he needed it. Resident #38 reported the nurse did not administer his pain medication until around 11:00 A.M. when she finally answered the call light. Interview on 06/04/25 at 9:36 A.M. with Licensed Practical Nurse (LPN) #502 revealed that she did care for Resident #38 on 05/31/25. It was her first day caring for him. She reported she was told in report that he wanted his pain medications every four hours but was not told what time his next dose was due. She confirmed she did not answer the call light until 10:40 A.M. and administered his pain medications then. LPN #502 reported that morning was busy, but the facility did have enough staff. LPN #502 also reported that she now is getting to know Resident #38 and is in his room every four hours if he hits the call light or not. Review of the undated facility policy labeled Pain Management revealed the healthcare facility recognizes the need to identify pain and its underlying cause, as able, that will allow for a prompt response to pain. This deficiency is an incidental finding identified during the complaint investigation.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of facility investigation and policy review, the facility failed to ensure Resident #53 received the ordered food texture resulting in her choking and requiring the Heimlich maneuver. This affected one (Resident #53) out of three residents removed for modified food texture and had the potential to affect 18 additional (Residents #5, #13, #20, #26, #30, #43, #47, #48, #55, #56, #71, #76, #78, #82, #86, #95, #100, and #101) identified by the facility as requiring a modified diet texture. The facility census was 99. Findings include: Review of the medical record for Resident #53 revealed an admission date of 08/26/24. Diagnoses included Huntington's disease and dysphagia. Review of the physician's order dated 08/26/24 revealed Resident #53 required regular diet with mechanical soft texture, and thin liquids. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #53 had moderate cognitive impairment. Resident #53 required extensive assistance for all activities of daily living and set up and cueing for eating. Review of the nursing progress note dated 05/13/25 at 5:30 P.M. revealed Resident #53 was eating in the dining room at 3:18 P.M. during an activity program and began choking on a piece of sausage. Initially, Resident #53 was able to talk but with continued coughing her airway became increasingly obstructed. The Heimlich procedure was done with five thrusts, and Resident #53 was able to cough out the food. She was assessed and vital signs were taken with no concerns for wheezing or shortness of breath. The physician was notified and a new order for vital signs every four hours for 24 hours was obtained. Review of the care plan dated 05/26/25 revealed Resident #53 required a mechanically altered diet. Interventions included to monitor consistency of diet served, and honor food preferences if able. Interview on 06/04/25 at 10:32 A.M. with Resident #66 revealed she had no concerns and reported she felt safe in the facility. Resident #66 reported she was there for the incident with Resident #53. Resident #66 pointed to Contracted Behavioral Health Aide #506 and reported that she gave her a bratwurst, and Resident #53 was not supposed to have it. Resident #66 confirmed that Resident #53 began choking, and the nurse had to do the Heimlich maneuver to get it out. Resident #66 reported it was scary to watch. Interview on 06/04/25 at 10:38 A.M. with Contracted Behavioral Health Aide #506 confirmed she did give Resident #53 the bratwurst, and she did choke on it and require the Heimlich maneuver. Contracted Behavioral Health Aide #506 reported that the facility keeps a logbook in the activity and lunchroom that states every resident's diet, and they were to check the book before giving any food to the residents. She reported that it was her second day at the facility, and she did not check. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 06/04/25 at 10:45 A.M. with Resident #53 confirmed she did eat the bratwurst and choked. She reported the nurse gave her the Heimlich maneuver, and she did not get hurt or have any problems after. Resident #53 reported she feels happy in the facility and had no concerns with her care. Review of the undated facility policy labeled Assisting a Resident with Feeding stated the staff member will verify the type of diet, consistency, and/or need for thickened liquids or devices with feeding prior to initiating feeding. This deficiency represents non-compliance investigated under Complaint Number OH00166091.