STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366217	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Court	1925 E Fourth St Ottawa, OH 45875

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 45751 Based on observation, resident interview, staff interview, and policy review, the facility failed to maintain a comfortable temperature throughout the facility. This affected 18 residents (#9, #10, #13, #15, #16, #17, #19, #22, #24, #29, #32, #33, #35, #36, #40, #42, #43, and #45) by the uncomfortable temperatures in the facility. Additionally the facility failed to maintain a clean and sanitary environment. This affected three residents (#8, #19, and #43) of 16 residents reviewed for environment. The facility census was 48. Findings include: 1. Observation and interview on 10/16/24 at 11:38 A.M. with Resident #33 revealed the heater not working or on at this time. Heater elements appear to be old and in disrepair. Cold air observed coming from the windows. Resident #33 stated his room was cold and he was cold last night. Resident #33 wanted his heater fixed. Interview and observation on 10/16/24 at 11:45 A.M. with Regional Director of Facility Management (RDFM) #156 confirmed their temperature gun showed a room temperature ranging from 60-65 degrees Fahrenheit (F) in Residents #33 and #22's room. Interview and observation on 10/16/24 at 12:02 P.M. with Resident #29 stated she was cold. Resident #29 was observed sitting on her bed with a winter coat on. Observation and interview on 10/16/24 at 2:48 P.M. with Maintenance Director #133 confirmed the facility's temperature gun showed the following room temperatures: Resident #42 and #36's room was 67.4 degrees F, Resident #16 and #40's room was 63.3 degrees F, the front hallway was 60.9 degrees F, Residents #15, #19 and #10's room was 64.4 degrees F, Residents #17, #29, #13, and #24's room was 64.9 degrees F, Residents #43 and #9's room was 69.0 degrees F, Resident #32 and #35's room was 65.3 degrees F, and the dining room was 69.0 degrees F. Maintenance Director #133 stated the air conditioning was still on in the facility. Observation and interview on 10/17/24 at 8:38 A.M. with Resident #45 revealed the resident was sitting outside their room with jacket on. Resident #45 stated it is warmer today than it was yesterday. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 10/17/24 at 8:44 A.M. with Resident #10 revealed the resident stated it is warmer in the facility today than it was yesterday. Resident #10 stated a few days back it was really cold in the facility. Review of the policy titled Quality of Life-Homelike Environment revised May 2017 revealed the facility staff and management shall maximize to the extent possible the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: comfortable and safe temperatures (71 degrees F to 81 degrees F). 37452 2. Observation on 10/15/24 at 10:03 A.M. revealed Resident #19's privacy curtain had a dried brown stain over an approximately three by six inch area, in a noticeable section of the curtain. During the observation, Resident #19 stated he had had an episode of bowel incontinence on the day prior, and feces had stained the curtain. Further observations on 10/16/24 at 8:45 A.M., at 11:56 A.M. and again at 4:33 P.M. revealed the dried feces was still present on Resident #19's privacy curtain. Interview on 10/16/24 at 4:33 P.M. with STNA #141 confirmed the noticeable dried brown feces stain on Resident #19's privacy curtain. The aide stated soiled privacy curtains were to be changed as needed. Interview on 10/17/24 at 9:55 A.M. with the Administrator confirmed staff were to let housekeeping know if a privacy curtain was soiled and required a change. Additional interviews on 10/17/24 at 11:29 A.M. with Housekeeping Aide #118 and at 11:53 A.M. with Housekeeping Director #119, further confirmed aides were to let housekeeping staff know if a privacy curtain was soiled and requires a change. 3. Observation on 10/16/24 at 12:13 P.M. revealed the room shared by Residents #43 and #8, had excessive spiderwebs in a corner from the floor to the ceiling, with debris scattered throughout the web and on the floor. Immediately following the observation, the excessive spider webs were confirmed by Regional Director of Clinical #157 and the Director of Nursing. Interview on 10/17/24 at 11:49 A.M. with Resident #43 stated they were relieved the spider webs were being addressed. Review of a policy titled Routine Cleaning and Disinfection, last reviewed August 2023, revealed the facility shall ensure provision of routine cleaning in order to provide a safe, sanitary environment and to prevent the development and transmission of infections. The policy stated curtains in resident rooms, shall be changed when visibly dirty and the cleaning of walls will be conducted when visibly soiled. Review of a policy titled Homelike Environment, last revised May 2017, revealed the facility shall provide a clean, sanitary environment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37452 Based on observation of medication administration, staff interview, and policy review, the facility failed to ensure the medication cart was secured at all times when unattended. This had the potential to affect all residents but three residents. The facility reported all residents were cognitively impaired and all but three residents were independently mobile or able to self-propel in a wheelchair. The facility census was 48. Findings include: Observation on 10/16/24 at 7:47 A.M. revealed Licensed Practical Nurse (LPN) #154 prepared medication at the medication cart which was parked adjacent to the dining room with the drawers facing away from the seating area. There was a half wall approximately two to two and one half feet high, between the cart and the actual dining room. During the observation, there were approximately ten to twelve residents in the surrounding area, with some residents arriving and departing breakfast service. After preparing medication for Resident #18, LPN #154 failed to lock the cart, walked away, and sat for approximately two minutes, in a chair next to the resident on the other side of an approximately five foot diameter round table. The nurse was facing in the direction of the cart which was approximately ten feet away, separated by the half wall and the round table. While administering medication to the resident, LPN #154 was observed to be focused on and looking at the resident. Additionally, this surveyor observed that while the nurse was seated, the nurse's view of the drawers were obscured considering the position of the cart, and the nurse would have been unable to see if a resident in a wheelchair approached the unlocked drawers. Interview immediately following this observation with LPN #154, confirmed the nurse walked away from the unlocked medication cart for approximately two minutes and was not fully attentive to the cart, despite the cart itself being within view. LPN #154 acknowledged the facility's population of residents with cognitive, mental, and behavioral health concerns, increased the need to ensure the cart was secure, and especially since the unlocked drawers were not within sight when she was seated at the table. Interview on 10/17/24 at 12:17 P.M. with the Director of Nursing confirmed medication carts were to be locked when out of sight or otherwise unattended. Review of a policy titled Medication Dispensing System, undated, revealed medication carts are to always be locked when out of sight or unattended.

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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. 44815 Based on observation, staff interview, and review of production recipes, the facility failed to ensure pureed foods were prepared properly. This affected one (#5) of one resident who received pureed food in the facility. The facility census was 48. Findings include: Observations beginning on 10/16/24 at 10:48 A.M. revealed [NAME] #109 receiving guidance from Dietary Director (DD) #114 regarding the preparation of one pureed portion of the noon meal. Interview with DD #114 revealed the noon meal consisted of beef pot roast, vegetable blend, mashed potatoes, and pumpkin pie. [NAME] #109 pureed and plated each food item separately. Observation of the pureed beef pot roast revealed a thick liquid with several small pieces of what appeared to be ground beef. Observation of the pureed vegetable blend appeared to be thin soup with several large pieces of vegetables. Observation on 10/16/24 at 11:55 A.M. revealed Resident #5 in the dining room received her noon meal tray with pureed items which included beef pot roast and vegetable blend. Interview and observation on 10/16/24 at 11:56 A.M. with DD #114 confirmed the vegetables delivered to Resident #5 were in a thin liquid with nearly intact pieces of vegetables. DD #114 confirmed the vegetables were not blended to a pureed texture and removed Resident #5's plate and explained he needed to re-prepare her meal. Telephone interview on 10/16/24 at 1:14 P.M. with Speech Therapist (ST) #158 revealed she had identified concerns with modified food textures, pureed and mechanical soft, at the facility and brought it to the facility's attention. ST #158 stated staff was receptive to re-education and training to ensure food textures were modified appropriately. Follow-up interview on 10/17/24 at 3:43 P.M. with DD #114, and concurrent review of the guidelines for preparing the pureed beef pot roast, revealed the pureed pot roast provided to Resident #5 during the noon meal on 10/16/24 was not pureed to a smooth texture. DD #114 stated he would have pureed it further but believed the lack of intervention by the surveyor indicated the texture was appropriate. Review of the Production Recipe for Vegetable Blend Mixed Pureed Thick, dated 03/31/21, revealed vegetables and melted margarine should be added to the food processor and processed until smooth in texture. Review of the Production Recipe for Beef Roast Pot Pureed Thick, dated 03/26/21, revealed beef pot roast and prepared broth should be added to the food processor and processed until smooth in texture.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44815 Based on observation, staff interview, and review of the dishwasher manufacturer's guidelines, the facility failed to ensure the dishwasher washed and rinsed dishes at temperatures specified by the manufacturer's guidelines. This had the potential to affect all 48 residents who received food from the kitchen. The facility census was 48. Findings include: Observation on 10/16/24 at approximately 11:00 A.M. revealed the dishwasher labeled with Machine Operational Requirements with a wash temperature of 120 degrees Fahrenheit (F) minimum and a rinse temperature of 120 degrees F minimum. Further observation revealed Dietary Director (DD) #114 running one cycle of the dishwasher and the was temperature reached 80 degrees F during the wash and a rinse temperature of 88 degrees F. Concurrent interview with DD #114 revealed the dishwasher was a low-temperature machine and should wash and rinse at approximately 100 degrees F and 110 degrees F respectively. Two additional wash cycles were run, and the dishwasher temperatures peaked at a wash temperature of 88 degrees F and a rinse temperature of 95 degrees F. Continued interview with DD #114 confirmed the manufacturer's guidance for wash and rinse temperatures were mounted on the dishwasher and indicated the minimum temperature for each were 120 degrees F. Interview on 10/16/24 at 11:26 A.M. with DD #114 and concurrent review of the Dish Machine temperature log for October 2024 revealed the dishwasher water temperature was documented three times daily and most documented temperatures were 100 degrees F wash and 110 degrees F rinse. DD #114 stated he would contact the dish machine company regarding the dishwasher temperatures not reaching manufacturer's temperature recommendations. Review of the Dish Machine temperature log for August 2024 revealed the dishwasher water temperature was documented three times daily (breakfast, lunch and dinner) and all documented temperatures were 100 degrees F wash and 110 degrees F rinse except dinner on 08/02/24 and lunch on 08/29/24 when the documented temperatures were 100 degrees F wash and 100 degrees F rinse, and lunch and dinner on 08/30/24 when the documented temperatures were 90 degrees F wash and 110 degrees F rinse. Review of the Dish Machine temperature log for September 2024 revealed the dishwasher water temperature was documented three times daily and all documented temperatures were 100 degrees F wash and 110 degrees F rinse except dinner on 09/26/24, 09/27/24, and 09/29/24 when the documented temperatures were 100 degrees F wash and 100 degrees F rinse.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37452 Based on observation, staff interview, medical record review, and review of policy for medication administration, the facility failed to practice appropriate hand hygiene during medication administration. This affected two residents (Residents #13 and #15) of three residents observed for medication administration. The facility census was 48. Findings include: Observation on 10/16/24 at 7:35 A.M. revealed Licensed Practical Nurse (LPN) #132 prepared 13 oral medications for Resident #13 by punching them from a punch card and/or removing them from a multi-dose container. During this preparation, LPN #132 touched each of the 13 tablets with bare skin while removing the medications from the packages and placing each them in the medication cup. LPN #132 then administered the medications to Resident #13. Observation on 10/16/24 at 7:41 A.M. revealed LPN #132 prepared six oral medications for Resident #15 by punching them from a punch card and/or removing them from a multi-dose container. During this preparation, LPN #132 touched each of the six tablets with bare skin while removing the medications from the packages and placing them in the medication cup. LPN #132 then administered the medications to Resident #15. Immediately following this second observation, interview with LPN #132 confirmed the nurse touched 13 medications for Resident #13 and six medications for Resident #15 with bare skin during preparation. Interview on 10/17/24 at 12:17 P.M. with the Director of Nursing confirmed nurses were not to touch medications with bare hands at any time. Review of a policy titled Medication Dispensing System, undated, revealed it directed the administering staff person, to not touch the medication when opening a bottle or unit dose package.

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F 0949 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 44815 Based on review of personnel files, record review, and staff interview, the facility failed to ensure newly hired State tested Nurse Aides (STNA) received specialty behavioral training. This had the potential to affect all 48 residents in the facility. Findings include: Review of the personnel file for STNA #142 revealed a hire date of 08/07/24. The file contained no evidence STNA #142 received training on mental health behaviors. Review of the personnel file for STNA #148 revealed a hire date of 08/15/24. The file contained no evidence STNA #148 received training on mental health behaviors. Interview and concurrent review of personnel files on 10/17/24 at 1:49 P.M. with Human Resources Director (HRD) #120 confirmed the facility provided no formal specialized training for mental health behaviors for newly hired staff. HRD #120 further confirmed STNA #142 and STNA #148 did not receive specialized training for mental health behaviors. Review of the Facility Assessment, dated 07/15/24, revealed the facility was a secure building, specializing in mental health behaviors.