Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235427	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER Autumn Woods Residential Hlth		STREET ADDRESS, CITY, STATE, ZIP CODE 29800 Hoover Rd Warren, MI 48093	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 This citation pertains to Intake MI00147638 Based on interview, and record review, the facility failed to prevent verbal and physical abuse for one resident (R801) out of four reviewed for abuse. Findings include: A review an investigation summary revealed the following, On 10/14/2024 at around 7:00 AM, Nurse D and Certified Nursing Assistant (CNA) E reported to A.D.O.N (Assistant Director of Nursing) . that they observed Licensed Practical Nurse (LPN) C yelling profanities at R801 for trying to sleep on the couch in the dayroom during their midnight shift on 10/13/2024 between 2:30am -3:30am. When R801 refused to get up off the couch LPN C continued to yell at them then got behind the couch and started lifting the couch to get R801 off. R801 then rolled onto the floor. Staff helped R801 up and took R801 to the room . A review of the medical record revealed R801 was admitted into the facility on [DATE] with the following diagnoses, Presence of Right Artificial Joint and Depression. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 99, indicating R801 was unable to complete the assessment. R801 also required staff assistance with bed mobility and transfers. On 10/24/2024 at 9:53 AM, R802 was observed in bed. R802 did not recall the incident or falling. On 10/24/2024 at 10:35 AM, a phone interview was conducted with Family Member (FM) H. FM H stated they were also the guardian of R802 and heard they had a fall. FM H stated they know R802 can be a little mean sometimes, but they have had a lot of falls in the facility. FM H stated they were not informed a staff member was involved in R801 falling on the floor. O 10/24/2024 at 12:33 PM, a phone interview was conducted with CNA E. CNA E stated LPN C was always verbally antagonizing residents or saying little mean stuff, but nothing to this degree. CNA E stated that was the first time they saw them harm someone or be that mean to a resident and they knew they had to report it. CNA E felt LPN C tipped the couch purposely to make R801 roll off. On 10/24/2024 at 1:21 PM, an interview was conducted with the Assistant Nursing Home Administrator (ANHA). The ANHA stated they were told about the incident and suspended the nurse immediately. The ANHA stated they reviewed the video and confirmed LPN C did act in an unacceptable manner, and they terminated LPN C. (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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	235427	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Woods Residential Hlth	29800 Hoover Rd Warren, MI 48093

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility policy titled; Abuse Policy noted the following. The resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Residents will not be subjected to abuse, neglect, or misappropriation of personal property by anyone.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 44750 Based on interview and record review, the facility failed to report an abuse allegation in a timely manner for one resident (R801) out of one reviewed for reporting. Findings Include: A review an investigation summary revealed the following, On 10/14/2024 at around 7:00 AM, Nurse D and Certified Nursing Assistant (CNA) E reported to ADON (Assistant Director of Nursing) . that they observed Licensed Practical Nurse (LPN) C yelling profanities at R801 for trying to sleep on the couch in the dayroom during their midnight shift on 10/13/2024 between 2:30am -3:30am. When R801 refused to get up off the couch LPN C continued to yell at them then got behind the couch and started lifting the couch to get R801 off. R801 then rolled onto the floor. Staff helped R801 up and took R801 to the room . A review of the initial report revealed that the incident was reported to the SA on 10/14/2024. On 10/24/2024 at 11:58 AM, an interview was conducted with ADON B. ADON B was asked why the incident was reported to the SA on 10/14/2024 when the incident occurred on 10/12/2024. ADON B stated the incident should have been reported immediately and that the nurses and certified nursing assistants involved were immediately educated, as well as the whole building for when to report allegations of abuse and who to report it to. ADON B stated when the incident was reported to them, they immediately informed the abuse coordinator and educated the staff that it should have been reported sooner. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: Element 1: R801 was immediately assessed fro injury and pain. Staff involved were immediately educated on reporting abuse Element 2: Like residents are all residents that reside on the nursing unit. Element 3: The Abuse policy has been reviewed and deemed appropriate. The DON (Director of Nursing)/designee will re-educate staff on when to report abuse and who to report it to Element 4: The DON or designee will review Incident reports for the last 14 days to determine if any incidents were deemed reportable. DON/Designee will also review the 24hr reports for the last 14 days to determine if any abnormal findings were documented related to resident's care. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Element 5: The Director of Nursing (DON) is responsible for overall compliance by 10/23/24. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.