STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235427	A. Building B. Wing	04/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Woods Residential Hlth	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 This citation pertains to Intake MI00152547. Based on observation, interview, and record review, the facility failed to ensure a clean environment for one resident, (R702) of three residents reviewed for home-like environment. Findings include: A review of the complaint submitted to the State Agency revealed the resident's room was observed as dirty upon visitation. On 4/28/25 at 10:58 AM, attempts to arouse R702 were made to no avail however, an observation of the resident's room revealed unidentifiable brown stains on the fitted and flat linen sheets the resident was laying on. The floor of the room was sticky underneath the surveyor's shoes, the door had what appeared to be an unidentifiable dried liquid on it, the baseboards throughout the perimeter of the room were observed as stained with an unknown caked on substance. The resident's bathroom was also observed with feces on the toilet seat. A review of R702's medical record revealed the resident was admitted into the facility on [DATE] with diagnoses that included Schizoaffective Disorder, Muscle Weakness and Hypertension. Further review revealed the resident had a severe cognitive impairment, and independent for transfers and bed mobility. On 4/28/25 at 12:32 PM, the Director of Nursing (DON) and surveyor observed the resident's room together, which was observed in the same condition as previously observed. The DON confirmed the room needed cleaning. A review of the facility's Room Cleaning Procedures revealed the following, Cleaning of every resident room is done daily .4. Sinks and Toilets are cleaned with a disinfectant cleaner inside and out .10 . flooring is dust mopped and then wet mopped with the specified floor cleaner. 11.Walls and doors are spot washed with a disinfectant cleaner when soiled. 12.Bathing Room tiles are wiped down and floors damp mopped with a disinfectant cleaner .

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