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	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Woods Residential Health	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intakes 1226813 and 2590504.Based on observation, interview and record review the facility failed to ensure call lights were in reach for four residents (R119, R160, R4 and R239) of six residents whose care needs were reviewed. Findings include: On 08/11/2025 11:19 AM, 11:25 AM, 1:11 PM, 2:00 PM, 2:56, and 4:34 PM, R4 was observed to be in bed with the call light on the floor at head of bed. R160 was observed to be in bed with the call light cord and button looped over a hook on the wall below the call box, and R119 was observed to be in bed, with the call light looped over the call box and vent cart. On 08/12/2025 8:18 AM, 9:17 AM, 11:30 AM, R4 was observed to be in bed with the call light on the floor at head of bed. R160 was observed to be in bed with the call light cord and button looped over a hook on the wall below the call box, and R119 was observed to be in bed, with the call light looped over the call box and vent cart. On 08/12/2025 at 11:37 AM, R239 was observed to be in bed with the call button hanging down below the bottom of the bed frame. On 08/13/2025 at 8:54 AM, R239 was observed to be in bed. An aide had exited the room re-entered and exited. The call cord and call button were on the floor at the left side of the bed. A review of the record for R4 revealed, R4 was admitted into the facility on [DATE]. Diagnoses included Renal Failure and Diabetes. The Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired cognition and total dependence on staff for Activities of Daily Living. A review of the record for R119 revealed, R119 was admitted into the facility on [DATE]. Diagnoses included Malnutrition and Respiratory Failure. The MDS dated [DATE] documented severely impaired cognition and total dependence on staff for Activities of Daily Living. A review of the record for R197 revealed, R197 was admitted into the facility on Diagnoses included Respiratory Failure and Stroke. The MDS dated [DATE] documented severely impaired cognition and total dependence on staff for Activities of Daily Living. A review of the record for R239 revealed, R239 was admitted into the facility on [DATE]. Diagnoses included Chronic Respiratory Failure and Diabetes. The MDS dated [DATE] documented severely impaired cognition and total dependence on staff for Activities of Daily Living. A review of the policy titled, Call Lights: Accessibility and Timely Response revised 12/28/23, revealed, The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance . Special accommodations will be identified on the resident's person-centered care plan, and provided accordingly. (Examples include touch pads, larger buttons, bright colors, etc.) .

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review facility failed to honor a resident's preference for a room change for one resident (R184) of three residents reviewed for rights and preferences. Findings include: On 08/11/2025 at 10:17 AM, R184 was asked about their care at the facility, R184 explained they were not happy. R184 expressed multiple concerns for them, locked closet with no access to clothes, not being allowed to leave the locked unit, not permitted to go outside since September 2024, and other residents wander in and out of their room. R184 reported they have made a request for a room change to Unit Manager (UM) G and Guardian P. R184 expressed staff do not listen to their concerns and feels very aggravated. On 08/12/2025 at 1:25 PM, an unknown male resident was observed sitting on R184's bed and putting on R184's tennis shoes. R184 remarked, this happens all the time, it's frustrating. The UM G was made aware of the observation and was then observed to remove the unknown male resident. A review of the medical record for R184 revealed, R184 was admitted to the facility on [DATE] with diagnoses of Diabetes, High Blood Pressure, and Dementia without Behavioral Disturbances. The Minimum Data Set (MDS) assessment dated [DATE], indicated R184 had a moderate cognitive impairment. On 08/12/2025 at 1:27 PM, Licensed Practical Nurse (LPN) H was asked about R184 care on the locked unit and indicated the environment is overstimulating for R184 affecting their desire to come out of the room for meals and activities. LPN H reported R184 often request to go downstairs to the vending machine, but staff is not always available and R184 has to wait.On 08/13/2025 at 8:21 AM, Social Worker (SW) E revealed R184 was moved initially to a private room on the locked unit after R184 was no longer able to get along with the roommate. After a 12-day hospital stay in December, R184 returned to a different room that was no longer the private room but now into a semi-private room on the locked unit. On 08/13/2025 at 8:45 AM, the Director of Nursing (DON) was interviewed about R184 being in a locked unit. The DON stated there is not specific criteria for placement on the locked unit.On 08/13/2025 at 10:54 AM, an interview with Registered Nurse (RN) J was conducted and asked about R184 documented behaviors. RN J reported behaviors are documented in the nurse's progress notes. A review of R184's medical record progress notes revealed, for June 2025 through August 11, 2025, revealed no documented behaviors. Further review revealed plan of care responses dated 07/13/2025 through 08/13/2025 with no documented behaviors. Further review of R184's medical record revealed a progress note from the Psychiatry Physician Assistant (PA) F dated 04/18/2025, [R184] reports frustration, stating [R184] does not want to be in the memory care unit and wants to be outside, as [R184] does not believe [R184] belongs there. [R184] reports[their] sleep has been poor and requests medication to help. [R184] also reports having anxiety as well as a little bit of depression . On 08/13/2025 at 11:20AM, attempt to reach PA F by phone was unsuccessful. On 08/13/2025 at 11:38 AM, attempted contact with R184's Guardian P, voice message was left with no return call by the end of the survey.On 08/13/2025 at 1:10 PM, a request was made for the facility's room change criteria policy. No policy was provided by the end of survey.

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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. This citation pertains to Intakes: 2578720, 2584022, 2586062 Based on interview and record review, the facility failed to thoroughly assess and document skin bruising for an injury of unknown origin for one resident (R50) of one reviewed for abuse. Findings include:A review of documentation submitted to the State Agency (SA), revealed R50 was admitted into the facility for 7-days of respite care, and was discharged with bruising on various areas of their body without explanation. The resident was taken to a community agency that coordinates healthcare services with the facility for a skin assessment, and was later transferred to the hospital for further evaluation. Further review of the documentation submitted noted photos of bruises in various healing stages most notably on the resident's body, specifically neck, left shoulder and hand.A review of R50's medical record revealed they were admitted into the facility on 7/22/25 and discharged on 7/29/25 with diagnoses which included Alzheimer's Disease, Severe Protein-Calorie Malnutrition and Diabetes. Further review revealed the resident was severely cognitively impaired, and required one-person assistance for toileting and transfers, and needed supervision for eating, ambulating and bed mobility. Further review of the medical record revealed a Nursing Evaluation Summary dated 7/22/25 noting no skin integrity issues for R50. On 8/13/25 at 10:47 AM, Licensed Practical Nurse (LPN K) was interviewed via phone, and confirmed she was the admitting nurse for R50. She explained that a skin assessment was completed for the resident, and did not identify any marks, bruises or wounds on the resident's body. Further review of the medical record revealed the following progress note:7/23/2025 19:53 (7:53pm) NP (nurse practitioner/PA physician assistant) Progress Note .Patient seen and examined at bedside. Chart reviewed; nursing assessment reviewed. Patient is being seen for chronic and any acute health conditions at this time . Skin: Intact with no visualized rashes .On 8/13/25 at 12:06 PM, an interview was completed with Certified Nursing Assistant (CNA N), assigned CNA to R50 the date of admission and discharge. CNA N explained that the morning of R50's discharge, she dressed the resident for the day and noted to have observed redness to the resident's right arm. CNA N explained that she reported the skin issue to a nurse, but didn't remember which nurse it was.A review of the Facility Reported Incident (FRI) revealed the following, . Although [R50] had multiple bruises of various stages of healing, we could not substantiate the causes of all the bruises, except the hand. We could however assess that they were most likely caused by [their] poor trunk control, unsteady gait, laying on [their] right side in awkward positions at various times prior to and during [their] stay. The bruises on [their] chest and shin appeared to be more advanced in healing than the hands, arm and shoulder. Indicating that they possibly occurred prior to the hand, arm and shoulder. The scratches on [their] thigh was due to a small area of irritation which [R50] scratched [themselves] .On 8/13/25 at 2:10 PM, an interview was completed with the Director of Nursing (DON), who acknowledged that she had seen the photos of R50 with the various stages of bruises. The DON explained that the facility could not determine how R50 sustained the bruising but admitted that something was missed by facility staff as it would have been impossible to have provided care to the resident and not have noticed the bruising. A review of the facility's Wound Care policy revealed the following, .2. All CNAs will check the resident's skin daily during routine care for evidence of skin injuries. Any new findings will be brought to the attention of charge nurse and/or Unit Management for immediate intervention .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to implement fall care plan interventions for one resident (R8) out of three reviewed for falls. Findings include:On 8/11/2025 at 11:32 AM, R8 was observed in the bed with a cane on the right side of the bed, R8 reported they use the cane for mobility. R8 reported they have had a couple falls in the facility.On 8/13/2025 at 10:56 AM, request for R8's Incident and Accident reports was requested but not received by the end of survey.A review of the care plan revealed the following intervention, Mat to floor next to bed left side of bed.On 8/11/2025 at 11:32 AM, no floor mat was observed on the left side of the bed.A review of the medical record revealed R8 was admitted into the facility on 5/5/2025 with the following medical diagnoses, Cerebral Infarction and Bipolar Disorder. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental status score of 14/15, indicating an intact cognition. R8 also required assistance with bed mobility and transfers.On 8/12 at 9:33 Am, no fall mat was observed on the left side of the bed.On 8/13/2025 at 10:37 AM, no fall mat was observed on the left side of the bed.On 8/13/2025 at 12:08 PM, an interview was conducted with Unit Manager (UM) W. UM W reported that were unsure why R8 did not have a fall mat and that maintenance may have moved it. On 8/13/2025 at 12:30 PM, a Quality Assurance and Improvement Plan (QAPI) meeting was held with the Nursing Home Administrator (NHA). The NHA reported they expect current fall interventions are expected to be implemented. The Interdisciplinary team (IDT) meets following a fall, the interventions should be reviewed and any intervention that is deemed appropriate will be added to the care plan and should be followed immediately.A request for a facility policy related to falls was requested but not received by the end of survey.