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	02/03/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. This citation pertains to intake 2626685.Based on interview and record review the facility failed to ensure interventions were implemented to monitor one resident (R901) of three reviewed for risk of elopement: Findings include:A review of the facility reported incident investigation summary revealed: On 01/21/2026 at approximately 8:45am, certified nursing assistant (CNA A) noted that (R901) was no longer sitting on the sofa where 45 minutes earlier. (CNA A) began looking for the resident. After not being able to locate (R901) staff from all departments began searching the facility inside and on the grounds. The Police Department was contacted due to the concern of cold weather. At approximately 9:15am, the police received a call from a medical clinic that an individual matching the description of (R901) was in their lobby .37 miles away, (R901) was returned to the facility and escorted to the secured unit. R901 ambulates with a steady gait and denied injury. The surveillance cameras were reviewed beginning at 7:15am. (R901) was observed in the hallway on one east low hall sitting in a chair. Staff were observed going up and down the hall. The nurse was present with the medication cart. At approximately 7:20am, (R901) got up from the chair, looked around and proceeded to go to the dayroom and sit down on the sofa. At 8:01am on the outdoor view of the employee entrance, (R901) was observed walking down the sidewalk toward the front of the building. The resident was admitted from (the hospital) on 01/20/2026 at 8:45pm with a diagnosis of Alzheimer's Dementia and was living alone prior to hospitalization. R901 was unable to answer questions for (Brief Interview for Mental Status) BIMs assessment. The nursing staff identified the risk for elopement and were monitoring the resident throughout the night shift. It appeared that the resident was actively waiting for an opportunity to exit the building and followed another resident who went out to smoke through the patio exit around 8:00am. On 02/03/26 at 12:29 PM, Licensed Practical Nurse (LPN) F reported they had been on the day R901 exited the building. LPN F reported R901 had only been in the facility less than 24 hours when the code for the elopement was called. They had heard R901 followed a smoker out. LPN F was asked about the alarm on the interior door R901 exited out of and reported they thought it was new. It was observed that the smokers exited into a fenced and gated courtyard.On 02/03/26 at 1:40 PM, an anonymous resident confirmed to be a regular smoker reported the alarms to the door for the smoker's exit were new and were not activated when the smoker went out during the day.On 02/03/26 at 2:08 PM, Unit Manager G reported the interior set of doors R901 walked out of was not alarmed before, but the second set of doors had always had an alarm. Unit Manager G reported the one east nurse would unlock the smoker's exterior exit doors in the morning and lock them again after 8 PM prior the elopement of R901. It was reported the doors were open for independent smokers to come and go without defined exit times from around seven am to seven pm. Unit Manger G was also the staff who returned R901 to the facility and noted R901 was confused by basic questions when picked up from the medical building. On 02/03/26 at 2:17 PM, LPN H reported they had observed R901 sitting in the gray chair in the siting area around the smoker's area exit doors with breakfast when they (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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	started their medication pass and within 45 minutes R901 was gone. LPN H reported the aides were also passing meal trays just like a regular day. LPN H reported R901 had not been in the facility 24 hours at that point and that the hospital had not disclosed the exit seeking concern for R901. LPN H noted that according to the night nurse R901 had attempted to exit and had to stop and that on follow up indicated R901 could have been moved upstairs sooner.On 02/03/26 at 2:41 PM, CNA A, reported they had been giving a resident a (15-20 minutes) shower when R901 exited building. CNA A reported they had last seen R901 around time they were done passing breakfast trays (like 7:50 AM). CNA A noted before R901 eloped residents could just go out and smoke during the day. CNA A reported they had not received any report from the night shift CNA about R901's exit seeking but did overhear the nurses talk about it during report. CNA A commented they had thought R901 was a visitor when first observed sitting in the hallway as they came on shift. On 02/03/26 at 3:00 PM, LPN I reported normal staffing on the unit when R901 arrived on the unit around 9PM as an unexpected admission. LPN I noted they did not receive any report from the hospital nurse, and the transport staff had not indicated R901 to be an elopement risk when asked. Diagnoses were urinary tract infection and dementia. LPN I further noted on assessment R901 did not recognize their own name and thought the transporters were friends. R901 had stayed in their room for a few hours until around 1:00 AM when R901 came out spoke with staff and went back into their room when redirected by staff. R901 came out of their room again around 4 AM and had been given something to eat and around five am R901 was out again looking for the bathroom. LPN I reported they had told the oncoming nurse that R901 was exit seeking may have to transfer to the second floor. LPN I further noted observed as they left the oncoming nurse was talking with two nursing assistants and told they had to keep an eye on R901. LPN confirmed that a CNA had overheard their report to the oncoming nurse. LPN I reported that prior to the elopement, the smoking exit was locked nightly and then unlocked before they left. On 02/03/26 at 3:40 PM, R901 was seated in their room playing a guitar. R901 did not recall leaving the building or being picked up and returned to the facility. The visitors indicated the forgetfulness and exit seeking were new. On 02/03/26 at 4:09 PM, the incident with R901 was reviewed with the Administrator and their assistant who indicated video of the elopement by R901 was no longer available. It was indicated they thought R901 was aware enough to wait for staff to leave the area before walking out with the smoker. A cause for the elopement was noted as the new surroundings and R901 looking for sisters or a girlfriend and interventions were not implemented to prevent the elopement of R901. It was also noted that based on bed availability, if a nurse observed exit seeking behaviors, they could call management to get the resident moved to the second floor. A review of the record for R901 revealed R901 was admitted in the facility 01/20/26. Diagnoses included Alzheimer's and Dementia. A review of the care plan documented , .at risk for altered activity patterns initiated 01/23/26 . has behaviors related to Dementia .Anxiety .Exit seeking .initiated 01/21/26 .A review of the facility Smoking Policy revised 01/2026 documented designated smoking times and the need for supervision during the smoking periods. Past Noncompliance received 02/03/26. POC date: 01/21/26. Compliance with POC noted upon observation, interview and record review on site 02/03/26.The IDT met on 1/21/26 for review of the incident. Immediate policy changes on the smoking times were changed to ensure the door would remain alarmed unless a staff member was actively supervising the area. All residents were reassessed for elopement risk. The Resident Council President was advised of the policy change and residents who smoke were informed in writing that smoking times were being limited. Additionally, education was provided to all staff that when a resident is assessed as being at risk for elopement, they should be moved to the secured unit. They were advised that the DON or NHA should be contacted if bed availability is an issue. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was not harmed and is adjusting to the secured unit without issues.Root Cause Analysis: Resident scored as a risk for elopement upon admission assessment and staff did not put an intervention in place to prevent (R901) from potentially leaving the facility.Element One: (R901) has returned to the facility and has been moved to Two East the locked unit. Upon returning to the facility the resident was assessed for pain and injury with none being noted. Resident was seen by the provider upon returning. Care plan was reviewed and updated.Element Two: Like residents are identified as residents that score as a risk on the elopement assessment. Elopement assessments completed on all residents and those identified at risk will have interventions placed and care plans updated.Element Three: The Unsafe Wandering and Elopement policy was reviewed and deemed appropriate. The ADON/Designee will educate nurses on immediately putting an intervention in place when a resident is deemed at risk. Education completed 01/21/26. Those not educated will be prior to their next scheduled shift. The Smoking policy was reviewed and updated. The ADON/Designee educated staff on smoke times and ensuring that the door is alarmed at all times unless scheduled. Education completed 01/21/26. Those not educated will be prior to their next scheduled shift.Element Four: Staff will audit patio door hourly to ensure that it is alarmed at all times unless it is a scheduled time. The clinical team will audit new admission charts daily to review the resident's elopement risk and ensure that for those at risk an intervention is in place,