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	07/25/2024

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34851 Based on observation, interview, and record review, the facility failed to provide showers, nail care, and facial hair removal for three sampled residents (R129, R61, and R79) of four reviewed for activities of daily living (ADLs). Findings include: R129 On 7/23/24 at 11:27 AM, R129 was observed lying in bed. R129 hair was observed with small white flakes at the surface of the scalp and throughout their hair. R129 was asked about the care at the facility. R129 stated, They rush when changing me. I don't get my showers hadn't had one in four weeks. R129 was asked if they had their hair washed. R129 stated, No. A review of R129 medical record revealed, R129 was admitted to the facility on [DATE] with the diagnosis of Parkinsonism. A review of R129's quarterly Minimum Data Set (MDS) assessment dated [DATE] noted R129 with a moderately impaired cognition and required assistance to completed activities of daily living. A review of R129's shower schedule revealed, Tuesdays and Fridays 2:00 PM-10:00 PM. A review of R129's shower documentation for 30 days noted, R129 with six bed bathes, no showers, and one refusal. On 7/24/24 at 11:51 AM, R129 was observed lying in bed, R129's fingernails were observed to be long with a buildup of dirt under them. R129 was asked if they received a shower. R129 reported, they did not get it, but the staff said they would get it today. On 7/25/24 at 10:11 AM, R129 was asked if they got their shower yesterday. R129 stated, No, because the thing (mechanical lift) is broke. On 7/25/24 at 10:12 AM, a mechanical lift was observed in the hallway and staff was observed to place a battery onto the lift, the lift was observed to work. On 7/25/24 at 10:14 AM, the Unit Manager K was asked about R129's shower and lift. Unit Manager K explained that R129 often refuses and the lifts works. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 at 10:15 AM, R129 was asked if they refused the shower when asked, R129 stated, No. R129 was asked if they preferred showers or bed baths, R129 stated, showers. R129 was asked if they refused for their hair to be washed, R129 stated, No, that's why I want a shower to wash my hair. R129's hair and nails were observed in the same conditions as previously observed. On 7/25/24 at 10:19 AM, R129's assigned Certified Nursing Assistant (CNA J) was asked about R129's shower that was scheduled yesterday. CNA J stated, [R129] didn't get one yesterday because we didn't have any slings (require equipment for the mechanical lift), this is a constant problem. [R129] did not refuse the shower yesterday. CNA J continued and explained some residents don't get up out of bed because we are out of slings and the slings are on a first come first serve basis. CNA J explained some residents hide them in their room at night so they can get out of bed in the morning. On 7/25/24 at 10:48 AM, an unidentified staff members were overheard asking for the mechanical lift. Staff #1 Do y'all have the (name of mechanical lift). Staff #2 Yeah. Do y'all have a sling I can use. Staff #1 The only sling I have is the one I am about to use to get this man up. Staff #2 Oh ok. On 7/25/24 at 10:59 AM, Unit Manager K was asked how many residents on the unit require mechanical transfers. Unit Manager K counted the residents and stated, 16 residents and multiple sizes (sling sizes). On 7/25/24 at 11:26 AM, the Nursing Home Administrator (NHA) was asked about the sling shortage. The NHA explained they ordered five on Monday, they were delivered, and each unit received one. A review of R129's care plan revealed, Focus: The resident has an ADL self-care performance deficit related to traumatic subdural hemorrhage, surgical aftercare, muscle weakness, unsteadiness of feet, morbid obesity, parkinson's disease, cognitive impairment and arthritis. Date Initiated: 08/25/2023. Goal: Resident's Activities of Daily Living (ADL) needs will be met through next review. Date Initiated: 08/25/2023. Interventions: BATHING: The resident requires total assistance of 1 person to bathe/shower. Date Initiated: 08/25/2023. R61 On 7/23/24 at 11:05 AM, R61 was observed in bed with long chin hairs. R61 was asked about their facial hair and stated, I get bed baths, but they don't shave me. R61 was asked if they preferred bed baths. R61 stated, Yes, but I don't prefer my chin hairs long. A review of R61's medical record revealed, R61 was admitted to the facility on [DATE] with the diagnosis of hemiplegia. A review of R61's annual Minimum Data Set (MDS) assessment dated [DATE] noted, R61 with an intact cognition and required assistance to completed activities of daily living. A review of R61's care plan revealed, Focus: Resident has an ADL self-care performance deficit related to chronic pain, hemiplegia, hemiparesis and limited mobility. Date Initiated: 08/10/2023. Goal: Resident's Activities of Daily Living (ADL) needs will be met through next review. Date Initiated: 08/10/2023. Interventions: PERSONAL HYGIENE: 1 person substantial assist. Date Initiated: 08/10/2023. 46956 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R79 Review of the facility record for R79 revealed an admitted [DATE] with diagnoses that included Osteomyelitis of the Left Ankle and Foot and Chronic Obstructive Pulmonary Disease. On 07/23/24 at 10:58 AM, R79 reported they were bothered by their toenails being too long and needing to be trimmed and stated they could not recall seeing a Podiatrist since their admission to the facility. On 07/24/24 at 11:54 AM, R79's feet were observed with staff assisting to remove the bedding and socks. R79's toenails were excessively long on multiple toes including some sharp, unfiled corners and particularly on the bilateral great toes which were approximately one inch beyond the nail bed. On 07/24/24 at 1:31 PM, the facility Director of Nursing (DON) reported non-diabetic residents can have their toenails trimmed by nursing staff and diabetic residents are referred to Podiatry for toenail care. On 07/24/24 at 1:43 PM, the DON observed R79's feet with the surveyor and acknowledged that multiple toenails needed to be trimmed. The DON reported their expectation is resident's who are not diabetic have their toenails monitored and trimmed during ADL (Activities of Daily Living) care as needed. A review of the facility's policy titled, Activities of Daily Living, dated 12/28/2023, revealed, Policy: The facility tasks measures to minimize the loss of residents functional abilities, including activities of daily living (ADLs). Activities of Daily Living include the ability to: 1. Bath, dress, and groom; 2. Transfer and ambulate . Review of the facility policy Nail Care dated 06/20/24 revealed the following Policy Explanation and Compliance Guidelines entries: 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. 4. Routine nail care to include trimming and filing, will be provided on a regular basis and as the need arises.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 Based on observation, interview, and record review, the facility failed to ensure a Peripherally Inserted Central Catheter (PICC- An IV-Intraveneous line inserted via the veins in the arm) dressing was dated and documented when changed for two residents (R82, R131) of two reviewed for PICC line care. Findings include: R82 On 07/23/24 at 9:24 AM, R82 was observed to be in bed, a rolled gauze dressing was observed to be wrapped around the left upper arm of R82. A single lumen PICC line cap was visible at the bottom edge of the the dressing. A date was not visible on the tape which held the dressing in place. The insertion site was not visible. An IV pump was observed at the left side of the bed. On 07/24/24 at 8:44 AM, 12:13 PM, 1:14 PM and 3:47 PM, R82 was observed to be in bed with the rolled gauze dressing wrapped around the left upper arm of R82. A single lumen PICC line cap was visible at the bottom edge of the the dressing. A date was not visible on the tape which held the dressing in place. The insertion site was not visible. An IV pump was observed at the left side of the bed. On 07/25/24 at 6:31 AM, R82 was observed to be in bed with the single lumen PICC line in place in the left upper arm. A undated rolled gauze dressing was wrapped around the left upper arm and the insertion site was not visible. The IV antibiotic was infusing. The dressing and site were observed with Licensed Practical Nurse (LPN) L. LPN L cut off the rolled gauze dressing to reveal no transparent dressing and no antibiotic bio-patch were in place over the insertion site of the PICC line. LPN L reported R82 received IV antibiotics daily at nine PM and six AM. LPN L reported the gauze dressing was in place because the prior PICC line had been pulled out by the resident. LPN L reported the dressing change was a sterile procedure and there should have been a transparent dressing in place under the dressing. On 07/25/24 at 6:51 AM, Unit Manager N acknowledged there should have been a date and transparent dressing in place. A review of the record for R82 revealed R82 was admitted into the facility 02/24/19. Diagnoses included Diabetes and Malnutrition. The June 2024 and July 2024 Medication Administration (MAR) and Treatment (TAR) Records were reviewed and documented administration of the IV antibiotics. Documentation of the PICC line dressing changes was not found. The MAR documented administration of the IV antibiotics in July (2024). R131 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/25/24 at 7:05 AM, R131 was observed to have a PICC line in place in the right upper arm. The PICC line was observed with Unit Manager M. The PICC line dressing was transparent but not dated. Unit Manager M confirmed it should be dated. The resident indicated the dressing may have been dated and rubbed off. No ink smear was visible. A review of the record for R131 with Unit Manager M revealed no documentation of the PICC line assessment or dressing change since R131's admission on 06/24/24. An order for a dressing change to be done weekly and as needed had been entered and 6:45 AM 07/25/24 by the infection control nurse O per Unit Manager M. Unit Manager M reported the IV was administered two times a day. A review of the record for R131 revealed R131 was admitted into the facility on [DATE]. Diagnoses included Osteomyelitis (bone infection) and Sepsis (blood infection). The June 2024 and July 2024 Medication and Treatment Records were reviewed and documented administration of the IV antibiotics. Documentation of the PICC line dressing changes was not found. On 07/25/24 at 7:32 AM, a review if the identified concerns was conducted with the Director of Nursing (DON). The DON reported PICC line dressings are to be transparent and changed weekly. The dressing was to be dated when changed and the PICC line and insertion site assessed when hanging each IV. The DON further noted there were no orders to change the PICC line dressings for R82 and R131 and subsequently no documentation of the dressing changes. A review of the policy titiled, PICC Insertion Using Modified Seldinger Technique dated 2/2009 revealed, .34. Cleanse the insertion site with three alcohol swabs, if necessary, secure the catheter with the V-lock security pad. Apply folded sterile 2x2 gauze sponge to the site. Apply transparent occlusive dressing. 35. A dressing change must be done every 7 days or sooner if compromised .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49699 This citation pertains to Intakes M100144913 and M100145603. This citation had two deficient practice statements. Deficient practice statement #1. Based on interview, and record review, the facility failed to ensure a mechanical lift sling was in good repair and two trained staff were present during transfer to prevent a fall from a mechanical lift for one (R494) of one resident reviewed for falls, resulting in a hospitalization . Findings include: Review of the facility record for R494 revealed an admitted [DATE] with diagnoses that included Cerebral Infarction with Left Hemiplegia, Muscle Weakness, and Anxiety Disorder. Additional review of R494's record revealed a progress note dated 7/8/2024, documented R494 had a fall (from a mechanical lift due to a ripped sling), subsequently assessed by nursing staff then reported the fall to Nurse Practitioner F. The note indicated R494 hit their head, was on blood thinners, and they had a throbbing headache, and sent to the emergency room . The Post-Fall assessment dated [DATE] reported pain in the back of their neck with the presence of a bump, skin intact and zero open lesions. The Fall-Initial-2 document dated 7/8/2024 revealed an elevated blood pressure of 175/101 with pain at the back of the neck/head at a pain level of 7 (severe pain) on a scale of 0-10 pain scale (0 being the least and 10 being the greatest pain). On 7/24/2024, at 11:30 AM, Certified Nursing Assistant (CNA) D was interviewed and described the process for mechanical lift use and confirmed they (facility staff) are lifting the patient from the bed, pushing the lift with the resident in it out into the hall to put in their chair. Per the manufactures guidlines, this causes the sling to swing and this increases the sling stress. At 02:30 PM, housekeeper E was interviewed and reported they were present and witnessed R494 falling from the mechanical lift sling. Housekeeper E indicated they were standing in the doorway during the transfer of R494, sort of spotting for the CNA H. Housekeeper E reported they heard a ripping sound and then the resident fell to the floor. At 1:45 PM, the facility Director of Nursing (DON) was interviewed. They reported their investigation revealed R494 was being transferred from the bed to a lounger-chair when a noise was heard and the resident fell to the floor. The DON reported while investigating the fall it was noted the mechanical lift sling was frayed and torn near the strap. The DON's investigation further revealed during the transfer there was one CNA H in the room and housekeeper E. The DON confirmed CNA H denied examining the lift pad prior to using it and was unaware of the potential for ripping. At 1:50 PM, the facility Administrator (NHA) reported their expectation that two nursing staff members would be present for all mechanical lift transfers. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Safe Lifting and Movement of Residents dated 1/1/2022 revealed the following entries: .Staff responsible for direct resident care will be trained in the use of mechanical lifting devices. The manufacturer of purchased equipment shall provide initial staff training on the use of mechanical lifts as well as on the routine checks and long-term maintenance of equipment. Subsequent training and retraining of staff on the use of mechanical lifting devices shall be conducted by designated team leaders .Two staff shall be present to assist during all patient lifts utilizing a mechanical lift. 34851 Deficient practice statement #2. Based on observation, interview, and record review, the facility failed to secure smoking/vape pens for one sampled resident (R97) of two reviewed for accidents. Findings include: On 7/23/24 at 9:12 AM, R97 was observed lying in bed with a vape pen attached to a necklace around R97's neck. R97 was observed to have the vape pen in their hand and was asked if they were allowed to use the vape pen in their room. R97 explained they were not supposed to but they did use it in their room and explained staff take too long to put them back in bed, so they don't go out to smoke. On 7/24/24 at 11:57 AM, R97 vape pin remain around their neck. On 7/25/24 at 10:55 AM, R97 was observed sleep in bed, the vape pen remained around R97's neck. On 7/24/24 and on 7/25/24 a unknown resident was observed with two packs of cigarettes on their lap as they moved about in an electric wheelchair. On 7/25/24 at 11:30 AM, the Social Service Director was asked the facility's policy with residents with vape pens and cigarettes. The Director stated the residents are to give their cigarettes to the nurses. The vape pens they can keep but should be following the smoking policy. The Social Service Director was asked if the residents are to use the vape pens in their rooms to which she responded, No. A review of R97's medical record revealed, care plan revealed, Resident is a smoker and will use vape pen at times can be noncompliant with policy here Date Initiated: 07/21/2023. Goal: Resident will follow and verbalize understanding regarding the facility rules for designated smoking areas and smoking material through next review. Date Initiated: 07/21/2023. Interventions: Inform resident or /family/responsible regarding the center's smoking policy, designated smoking areas, and storage of smoking materials. Date Initiated: 07/21/2023. Other: Resident has been educated RE: use of vape pen prohibited in room. Date Initiated: 07/21/2023. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Smoking Policy, dated 5-2024 Standard: (facility) provides a smoke-free environment as well as safe designated smoking area Policy: 1. Upon admission, residents and family will be notified of the facilities no smoking policy 2. Smoking is not permitted anywhere inside the building by at any time by staff, visitors, or residents. Anyone found smoking will be reminded of the policy and escorted to the designated area. Disciplinary warnings will be issued to staff . 7. All smoking materials must be kept at the nursing station when the resident lives unless they are deemed safe by Resident Services. Smoking materials kept at the nursing station will be labeled with the resident's name. Materials may only be used for that resident .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34851 Based on observation, interview, and record review, the facility failed to store medication in a safe and secure manner for four (R97, R102, R11 and R33) of the 35 total sampled residents, reviewed for medication and storage. Findings include: R97 On 7/23/24 at 9:12 AM, R97 was observed lying in bed. R97's overbed table was observed with a single white pill in a medication cup. R97 was asked how long the pill had been in their room. R97 stated, I don't know, maybe this morning. R97 was asked what the pill was for, R97 was observed to move their hands and said neuropathy (nerve damage). R102 On 7/23/24 at 11:22 AM, R102 was observed in their room with a medication cup that had one orange gel capsule, the cup was observed in their window seal. R102 was asked about the pill. R102 stated, I didn't take it because I had a bowel movement this morning. I told the nurse I didn't want it. R111 On 7/23/24 at 2:19 PM, R111 was observed in their room with a red inhaler on the overbed table. R111 was asked if they normally keep the inhaler in their room and said, they didn't know. R33 On 7/23/24 at 11:48 AM, R33 was observed in bed and was interviewed about their stay at the facility. During the interview R33 was observed to pull a small plastic bag out that appeared to have over 20 pills. R33 was asked about the bag of pills and if the facility knew they had them in their room. R33 stated, I am not taking these. I don't need these. A review of R33's medical record revealed, R33 was admitted to the facility on [DATE] and readmitted on [DATE] with a diagnoses of Major Depressive disorder, Dementia with Mood disturbance, Adjustment disorder with mixed anxiety and Depressed Mood. On 7/24/24 at 1:14 PM, the Director of Nursing (DON) was shown the plastic bag of pills and was asked to identify the pills. The DON counted the pills which totaled 28 pills. The DON was asked the facility's expectation for medication administration and storage and said that inhalers and medications are to be taken with the nurse in the room and if the resident refused the medication, it is to be taken back out of the room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy titled, Medication Storage dated 1/30/24, noted, Policy: It is the policy of this facility to ensure all medications housed on our premises will be stored according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security .

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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. 22960 Based on observation, interview, and record review, the facility failed to maintain the sanitizer buckets, failed to ensure dishware was dry before stacking, and failed to ensure resident food items were dated. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 7/23/24 between 8:55 AM-9:30 AM, during an initial tour of the kitchen with Dietary Staff P, the following items were observed: There were 2 red sanitizer buckets with wiping cloths inside observed in the kitchen area. Dietary Staff P stated the buckets contained sanitizer solution. The sanitizer level in both buckets was tested with a test strip, and the strip did not change color to denote the presence of sanitizer solution in the buckets. Dietary Staff P stated the buckets would be changed. According to the 2017 FDA Food Code, Section 3-304.14 Wiping Cloths, Use Limitation, .(B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114; On the clean dishware rack, there were stacks of metal pans, with visible water droplets/moisture observed on the inside of the pans. Dietary Staff P confirmed the pans should have been dry before stacking. According to the 2017 FDA Food Code section 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, .(B) Clean equipment and utensils shall be stored as specified under (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; . On 7/23/24 between 2:30 PM-2:45 PM, the resident refrigerators were observed with Housekeeping/Laundry Supervisor Q. In the 1 [NAME] refrigerator, there were 8 undated plastic containers with various food items (spaghetti, soup, [NAME] sauce, etc.). Housekeeping/Laundry Supervisor Q confirmed all items should have been dated. In the 1 East resident refrigerator, there was a bag of cut watermelon dated 7/15 and several black, mushy bananas. Housekeeping/Laundry Supervisor Q confirmed the items should have been discarded. Review of the facility's policy Food(s) brought in from outside the facility with an effective date of 9/2019 noted: 1. Foods brought in from an outside source must be stored in sealable containers, labeled with the resident's name and dated . 5. Acceptable foods that require refrigeration will be kept for 48 hours and then discarded.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46956 Based on observation, interview, and record review, the facility failed to repair or replace a bed in disrepair for one (R136) of eight resident's reviewed. Findings include: Review of the facility record for R136 revealed an admitted [DATE] with diagnoses that included Infection of the Right Ankle and Foot, Diabetes Mellitus with Diabetic Neuropathy, and Muscle Weakness. The record indicated that R136 was most recently readmitted to the facility on [DATE] following a Right Above Knee Amputation. On 07/23/24 at 11:17 AM, R136 reported the height adjustment of their bed had not worked since I've been here. The resident demonstrated using the remote control that the head and foot adjustments worked and when they attempted to adjust the bed height the bed did not move and it made a loud grinding noise. R136 stated they had reported this issue to staff and it was never addressed. On 07/24/24 at 12:03 PM, R136 was interviewed further regarding the reporting of their bed malfunction. When asked if they could identify specific staff members they reported the situation to the resident stated I don't know their names but I've told multiple people from maintenance to nurses, everybody, for months. On 07/25/24 at 9:11 AM, Certified Nursing Assistant (CNA) A reported they were assigned to R136 and they had worked with and were familiar with R136. When asked if they were aware the bed height does not adjust CNA A reported the bed height does adjust but the button had to be held down and after a delay the bed would move. CNA A reported the bed does make a loud noise but it will move after a delay. CNA A demonstrate the function of the bed and when the height adjustment was attempted the bed made a loud grinding noise and the bed did not move. CNA A stated No that doesn't work, I thought you meant the head adjustment. CNA A was asked if they had ever reported the bed dysfunction to maintenance and they stated No, I haven't. On 07/25/24 at 9:25 AM, Licensed Practical Nurse (LPN) B reported they were familiar with R136 and indicated they were familiar with the grinding noise the bed makes with attempted adjustment. LPN B reported they had not reported any issue with R136's bed to maintenance. On 07/25/24 at 9:31 AM, the facility Maintenance Director (MD) was asked how maintenance issues are reported/received from facility staff or residents. The MD indicated the facility was integrating a computer-based work order reporting but paper work orders continued to be the primary means of reporting. The MD said work orders are completed by staff and are collected by maintenance staff at the nurses' stations. The MD reported they were not aware that R136's bed was in disrepair and indicated there were no work orders indicating such. On 07/25/24 at 2:25 PM, the facility Director of Nursing (DON) reported the expectation when nursing staff are made aware of resident-use equipment being in disrepair is they report it directly to maintenance or complete and submit a work order. (continued on next page)

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	07/25/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy pertaining to reporting of malfunctioning equipment and the work order process was requested. The facility Adminstrator (NHA) reported that they were not able to identify a policy that addressed this area.