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

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure formulated advance directives were completed properly for one resident (R8) out of two reviewed for advanced directives. Findings include: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.Further review of the medical records revealed a capacity determination letter signed by a physician on 5/14/2025 and a Licensed Psychologist on 5/12/2025, deeming R8 incapable of making decisions regarding medical treatment. As well as an advance directive signed by R8 dated 7/2025.On 8/13/2025 at 11:23 AM, an interview was conducted with Social Service Director (SSD) D. SSD D reported R8's sisters were supposed to be getting guardianship, but they did not know where they were in the process and would have to follow up. SSD D reported they did the capacity determination because they needed to know what her capabilities were to make decisions. SSD D was asked why R8 signed their own advance directives after being deemed incompetent. SSD D stated they allowed R8 to sign their own advance directives at the time because they seemed coherent enough, although no new capacity determination had been completed.A request for a facility policy related to advance directives was requested but not received by end of survey.

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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** Based on observation, interview, and record review the facility failed to maintain a homelike environment for two sampled residents (R151 and R184) of six reviewed for environment. Findings include: R151On 8/12/2025 at 9:38 AM, R151 was sitting in a wheelchair in their room. R151's bed footboard was observed to be in disrepair with exposed wood and with duct tape around it. On 8/13/2025 at 9:44 AM, R151's bed remained in the same condition. R151 was asked about the condition of the footboard and provided no explanation about its condition. A review of R151's medical record revealed that R151 was admitted to the facility on [DATE] with diagnosis of Alzheimer's. A review of R151's Minimum Data Set (MDS) assessment dated [DATE] noted R151 with impaired cognition. A review of R151's care plan noted, Focus: Resident has impaired cognitive functioning r/t (related to) Dementia, Intellectually Disabled, decreased memory, decision making, difficulty w/recall, impaired thought processes. Date Initiated: 12/17/2024. Goal: Resident will have reduced complications related to their cognitive function through next review. Date Initiated: 12/17/2024. Interventions: Encourage family/responsible party to bring in familiar personal items to promote a homelike environment. Date Initiated: 12/17/2024.On 8/13/2025 at 2:13 PM, the Maintenance Director was asked about the condition of R151's footboard and explained he was not aware of the bed being an issue.R184On 8/11, 8/12, and 8/13/2025, R184's floor tile was observed to be in chipped, stained, and in disrepair. A review of the facility's policy titled, Maintenance Inspection dated, 3/12/22 noted, Policy: It is the policy of this facility to utilize a maintenance inspection program in order to assure a safe, functional, sanitary, and comfortable environment for residents, staff, and public. Policy Explanation and Compliance Guidelines: 1. The Director of Maintenance Services will perform routine inspections of the physical plant using the TELS program.

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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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to complete an annual pre-admission screening and resident review (PASARR) for one resident (R8) out of two reviewed for PASARR's. Findings Include: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.A review of the most recent PASARR was dated 6/28/2024.On 8/13/2025 at 11:23 AM, an interview was conducted with the Social Service Director (SSD) D. SSD D reported they would have to look and see if an annual was completed for R8.A request for an updated PASARR for R8 was requested and not received by the end of the survey.A request for a facility policy related to PASARR completion was requested and not received by end of survey.

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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.

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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. Based on observation, interview, and record review the facility failed to provide routine finger nail care for two sampled residents (R16 and R20) of six reviewed for activities of daily living. R16On 8/12/2025 at 9:25 AM, R16 was observed in bed with long nails, with a yellowish tint, and a buildup of brown debris under them. R16 was asked if they preferred their nails at the observed length. R16 was observed to hold their hands up towards their face and expressed that the nails were long and that they should be cut. On 8/13/2025 at 9:40 AM, R16 was asked if the staff had cut their nails, R16 reported they had not been cut. R16's nails were observed in the same condition.On 8/13/2025 at 9:47 AM, Unit Manager, Licensed Practical Nurse (LPN A) was asked to observe R16's nails. LPN A expressed, R16's nails were long and needed to be cut. LPN A was asked the expectation for resident's nails to get cut. LPN A explained, it is as needed, and nails are to be checked on shower days.A review of R16's care plan noted, Focus: The resident has an ADL self-care performance deficit related to absence of right leg below knee, history of joint replacement surgery and muscle weakness. Date Initiated: 08/14/2023. Goal: Resident's Activities of Daily Living (ADL) needs will be met through next review. Date Initiated: 08/14/2023 Revision on: 03/13/2025. Interventions: PERSONAL HYGIENE: Dependent - 1 person assist Date Initiated: 08/14/2023.R20On 8/11/2025 at 9:52 AM, R20 was observed laying on their bed, R20's nails were observed to be long and with brown debris under their nails.On 8/13/2025 at 9:40 AM, R20's nails remained in the same condition. R20 was asked if they preferred their nails at that length, R20 explained, the nails needed to be cut. On 8/13/2025 at 9:50 AM, LPN A made an observation of R20's nails and was asked when R20's nails are to be cut. LPN A explained that she will cut them if R20 lets them. LPN A was asked if R20's refusal was documented or care planned. LPN A stated staff have been directed to document refusals and that she was not sure if it was care planned.A review of R20's care plan noted Focus: The resident has an ADL self-care performance deficit related to dementia, muscle weakness, osteochondritis dissecans, chronic kidney disease, old myocardial infarction and hypertrophic disorder of the skin. Date Initiated: 11/30/2023. Goal: Resident's Activities of Daily Living (ADL) needs will be met through next review. Date Initiated: 11/30/2023. Interventions: PERSONAL HYGIENE: Supervision - offer setup help as needed Date Initiated: 03/11/2024.On 8/13/2025 at 2:06 PM, the Director of Nursing (DON) was asked the expectation for nail care, the DON explained that nail care is to be completed during activities of daily living care.A review of the facility's policy titled, Nail Care dated, 8/20/24 noted, Policy: The purpose of this procedure is to provide guidelines for the care of a resident's nails for good grooming and health. Policy Explanation and Compliance Guidelines: . 3. Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis .

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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. Based on interview and record review, the facility failed to schedule a hematology (specialty for diseases of the blood) appointment for one resident (R8) out of one reviewed for consultation appointments. Findings Include:On 8/13/2025 at 10:40 AM, R8 was observed in their bed. R8 stated they were doing okay, but their hands have been hurting them.A review of the medical record revealed R8 admitted into the facility on 3/7/2025 with the following medical diagnoses, Chronic Obstructive Pulmonary Disease and Obstructive Sleep Apnea. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental status score of 12/15, indicating an impaired cognition. R8 also required assistance with bed mobility and transfers.Further review of the medical record revealed an active order with a start date of 3/18/2025 for a hematology appointment follow up.On 8/13/2025 at 2:05 PM, an interview was conducted with the Director of Nursing (DON). The DON reported they were unaware of a hematology appointment and would look into it.No further information was received by the end of the survey.A request for a policy related to outside appointments was requested and not received by the end of survey.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure timely monitoring for two ventilator residents (R3, R35) of four residents reviewed for respiratory care needs. Findings include: R3 On 08/11/2025 at 9:36 AM, R3 was observed to be in bed and restless with non-purposeful movements of the arms and legs. R3 had a tracheostomy (artificial airway inserted via a throat incision) which was connected to a mechanical ventilator (assists resident to breath effectively) via a corrugated plastic tubing (circuit). On 08/11/2025 at 10:42 AM, R3's restlessness continued and the circuit connecting the tracheostomy to the ventilator became disconnected at the tracheostomy site with a movement of R3's left arm which tangled the circuit tubing. An alarm sounded and a red light turned on above the outside of the resident's doorway. No staff were observed to be in the hallway. At 10:44 AM, staff came around the corner from the nurse station, turned back toward the nurse station and then walked up the hall to the room of R3 and reconnected the circuit to the tracheostomy. On 08/12/2025 at 8:08 AM, 9:15 AM, 11:23 AM, and 2:29 PM, R3 was observed to be in bed, calm and without restlessness. A review of the record for R3 revealed R3 was admitted into the facility on [DATE] and most recently re-admitted on [DATE]. Diagnoses included Tracheostomy Status and Dependence on a Ventilator. A review of the Minimum Data Set (MDS) assessment dated [DATE] documented moderately impaired cognition and dependence or the need for substantial/maximal assistance for activities of daily living. R35On 08/11/2025 at 9:46 AM, R35 reported staff had taken 45 minutes to respond to their call light and get them onto the beside commode. R35 had a tracheostomy connected to a mechanical ventilator. R35 then reported they had become disconnected from the ventilator on 08/10/25. At 11:33 AM, R35 was observed to be seated upright in a recliner at the left side of the bed. R35 reported it had taken twenty minutes for staff to respond to the call light to get them off the bed side commode earlier in the morning. R35 was asked about what happened on 08/10/25. The spouse was present. R35 related they did not recall how the circuit became disconnected nor how long they were disconnected. The spouse indicated R35 had quit breathing. R35 recounted the tube had become disconnected in two places. This was identified as at the tracheostomy site and at the inline valve along the circuit tubing. R35 noted they had been showered earlier in the morning and was up in the recliner as on any other day. R35 recalls putting on the call light to use the bathroom and a few minutes later the circuit had become disconnected. R35 reported they were able to get the circuit reconnected at the valve but not at the tracheostomy. R35 reports they struggled with the tubing and trying to breath and may have passed out. The spouse reported they had spoken with R35 around 11 AM and R35 was fine. The spouse reported they had arrived in the room at the time staff were in with R35 on 08/10/25 and reported R35 was out of it at the time. The spouse reported additional times R35 has had to wait longer than 20 minutes for assistance to get back into bed. R35 was observed to be able to suction themselves, pedal a foot bike independently, feed themselves and converse appropriately during the days of the survey. On 08/11/2025 at 10:10 AM, Respiratory Therapist (RT) O reported someone should have heard the alarms going off. They had returned from break and noted the incident with R35. RT O reported R35 may have been disconnected for about three minutes. RT O reviewed the alarm menu for R35's ventilator and reported the last disconnection on 08/10/25 was at 12:14 PM. RT O also noted alarms for low pressure and low volume. On 08/11/2025 at 4:26 PM, the Corporate RT Director RT Q reported there should be an immediate response from staff to red light alarms. On 08/12/2025 at 11:23 AM, R35 was seated in a recliner using a foot bike independently. On 08/12/25 at 11:26 AM, the alarm activations were reviewed with RT X and confirmed disconnection means the circuit was disconnected and started at 12:08 PM and continued to alarm at 12:09 PM, 12:10 PM, 12:11 PM, 12:13 PM and 12:14 PM. An explanation of the alarms was not provided. On 08/13/2025 at 7:58 AM, R35 was asked again to review the events of 08/10/25. R35 reported it was a regular day with the regular (continued on next page)

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	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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	routine. R35 reported they were up in the recliner with the circuit tubing off toward the right. They had put on the call light to use the bathroom and the call light had been on for two or three minutes, when circuit became disconnected in two places one at valve and at tracheostomy site. R35 reported they were able to reconnect at valve, but was not able to reconnect at the tracheostomy site. R35 reported they were struggling to breath and does not recall any coughing. On 08/13/2025 at 8:02 AM, RT O, reported that the unit was fully staffed on 08/10/25 but they had gone on break around 11:30 AM. RT O also reported that when the monitor reads disconnection it is only a disconnection, otherwise will say low minute volume or low pressure. On 08/13/2025 at 10:06 AM, R35 was seated in a recliner, suction wand in hand, sitting straight upright, and watching TV. On 08/13/2025 at 10:10 AM, the unit manager for the vent unit was asked to review the alarm activations for 08/10/25. Minute by minute low pressure, low minute volume and disconnect alarms were recorded from 12:08 PM until 12:14 PM. The unit manager reported they would have to speak with the corporate RT manager to review the settings. At 11:11 AM RT Manager Q reviewed alarm activations from 12:08 PM to 12:14 PM and noted the alarm activated and reset in the same minute. RT Q speculated R35 may have been coughing or putting it on and off. It was noted that R35 had attempted to reconnect the circuit to the tracheostomy, but was not able to. It was further noted that there was alarm activation for a period of six minutes when additional review of the alarms indicated only a single event, not seven in succession as on 08/10/25. On 08/13/2025 at 11:27 AM, the Director of Nursing (DON) reported they had spoken with the staff involved in regard to the disconnection of R35 from the ventilator. The DON reported they were shown where R35 may have been off the ventilator for two to three minutes. The DON deferred to the corporate RT Manager for vent unit concerns. On 08/13/2025 at 11:47 AM, Certified Nursing Assistant (CNA) S (R35's assigned CNA) reported it was busy on the opposite hall with more high level or red alarms which needed attention. CNA reported they had completed the lunch tray pass between 11 AM and 11:30 AM and had gone to the restroom sometime after that. Upon returning to the unit, they noted the red alarm for R35 was activated and went into see R35 and observed R35 disconnected from the ventilator. CNA S reported RT R and Licensed Practical Nurse (LPN) T responded first. CNA S reported R35 kept leaning, not able to sit upright and R35's speech was not clear. On 08/13/2025 at 12:01 PM, LPN U reported they were on the vent unit on the opposite hall from R35 on 08/10/25. LPN U reported it was a busy day as two residents had been alarming off and on, all day and one of the resident's had to eventually be sent out. LPN U noted the nurse from the other hall was trying to help them also. On 08/13/2025 at 12:07 PM, LPN T reported R35 was lethargic and had a deer in the headlights look when they entered the room of R35 during the disconnection on 08/10/25. LPN T confirmed it was a busier than usual day and noted they had been down the other hall when CNA S called them. LPN T also noted around 12 PM the aides would have been in the rooms doing vitals. A review of the record for R35 revealed R35 was admitted into the facility on [DATE]. Diagnoses included, Acute and Chronic Respiratory Failure, Tracheostomy Status, Dependence on Ventilator and Dependence on Supplemental Oxygen. A review of the Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition with a Brief Interview for Mental Status score of 15/15 and the need for supervision for eating, and dependence for toileting, and transfers. The active care plan did not provide interventions related to alarm response. A review of the user manual for the facilities ventilators revealed in section six: low minute volume alarm, priority high, will be given when the monitored minute volume does not reach the alarm limit for 15 seconds. Possible cause: mismatch between breath rate and inspired volume. changes in airway resistance and or compliance, decreased breath rate . A low pressure alarm will be given when unit fails to reach the low pressure limit for 15 seconds. Possible cause: disconnection of patient circuit, mismatch between pressure setting and alarm setting, leakage from mask or other components . Disconnection: when measured flow exceeds the expected leakage flow at the set pressure for 15 seconds. Possible causes: too high leakage, has removed mask, circuit disconnection, pilot pressure tube disconnection, patient circuit or cannula disconnection . A review of the undated facility information sheet titled, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ventilator Alarms revealed, Check Circuit Alarm = Pinched or detached tubing, problem with exhalation valve, too high of pressure; Circuit Disconnect = tubing detached; High inspiratory pressure = cough, pinched tubing, bearing down needs suctioned; Low Minute Ventilation = Leak in Circuit, not getting adequate breaths; Low expiratory pressure = leak in circuit, might need air in cuff.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interview and record review, the facility failed to provide mental health services in a timely manner for one resident (R186) out of three reviewed for mood and behavior. Findings include:A review of the medical record revealed R186 admitted into the facility on 5/13/2025 with the following medical diagnoses, Schizophrenia and Bipolar Disorder. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 12/15, indicating an impaired cognition. R186 also required assistance with bed mobility and transfers.Further review of the physician's orders revealed that R186 received Haldol (Antipsychotic) injection, once a month.On 8/13/2025 at 11:04 AM, a request for psychiatric notes for R186 was requested and not received by the end of survey.On 8/13/2025 at 11:23 AM, an interview was conducted with Social Service Director (SSD) D. SSD D reported they are on the list to be seen, and they just switched to a new Nurse Practitioner. SSD D reported the new Nurse Practitioner comes in every Monday and will be seeing R186 soon.On 8/13/2025 at 12:30 PM, a Quality and Performance Improvement (QAPI) meeting was held with the Nursing Home Administrator (NHA). The NHA stated they expect Psychiatry (Psych) evaluations should be completed within the first week of admission pending consent by either the resident or guardian/power of attorney. They reported the Psychologist is here every other week and the Psych Physician's Assistant is here weekly. The NHA reported that consents for treatment can be verbal if documented and sometimes the psych evaluation is delayed or does not happen if consent is not provided.A request for a facility policy related to behavioral services was requested and not received by the end of survey.

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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. Based on observation, interview, and record review the facility failed to ensure safe storage of medication for one resident (R149) of four residents reviewed for medication storage. Findings include:On 8/11/25 at 9:49 AM, an observation on R140's bedside table, a medication cup of pills containing approximately eight pills, two blue oval, two large round white, one small round white, one small yellow round, one white capsule, and one yellowish clear gel capsule. Two bottles of Nystatin Powder were also on the bedside table on 8/11/25, 8/12/25, and 8/13/25. When R149 was queried, they revealed their nurse always leaves the pills for them to take when they are ready. Further inquiry revealed R149 identified the medication as some are blood pressure pills. They also indicated the powder is for under my folds.A review of the Electronic Medical Record (EMR) revealed on 4/7/23, R149 was admitted with the following relevant diagnoses: End Stage Renal Disease with dependence on Renal Dialysis, Chronic Heart Failure, Diabetes, Dependence on Oxygen, and Polyosteoarthritis. Further review of R149's EMR revealed intact cognition. The EMR further revealed R149 used a walker and/or wheelchair for mobility and required partial/moderate assistance for basic activities of daily living. On 8/13/2025 at 11:57 AM, Licensed Practical Nurse (LPN) B revealed R149 liked to have their meds given to them to take on their own time. On 8/13/2025 at 1:00 PM, the Director of Nursing (DON) revealed that medications should not be at the bedside, the nurse is expected to watch the resident consume medications.A review of the EMR revealed the resident did not have a Self-Medication Administration Assessment. A review of the facilities policy Medication Administration dated 1/17/2023 revealed . 15. Observe resident consumption of medication .A review of the facilities policy titled, Medication-Resident Self-Administration of, dated 1/30/24 revealed the following .3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following: a. The medications appropriate and safe for self-administration; b. The resident's physical capacity to: swallow without difficulty, open medication bottles, and administer injections; c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for; d. The resident's capability to follow directions and tell time to know when medications need to be taken; e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff: f. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs; and, g. The resident's ability to ensure that medication is stored safely and securely. Further the policy states .7. Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication. The following conditions are met for bedside storage to occur: a. The manner of storage prevents access by other residents. Lockable drawers or cabinets are required only if locked storage is ineffective. b. The medications provided to the resident for bedside storage are kept in the containers dispensed by the provider pharmacy .13. The care plan must reflect resident self-administration and storage arrangements for such medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly store a nebulizer mouthpiece for two residents (R6 and R191) out of two reviewed for nebulizer storage. Findings include:R6 On 8/13/2025 at 10:40 AM, R6 was observed in bed and wearing oxygen. R6 reported they were about to get out of bed and in their chair. A nebulizer mouthpiece was noted to be laying on the nightstand, with no barrier beneath it and an undated line. R6 was asked if they use the nebulizer mouthpiece often and they stated they use it everyday. On 8/13/2025 at 1:02 PM, Licensed Practical Nurse (LPN) “V”. LPN “V” reported they do store the nebulizer mouth pieces in a bag. LPN “V” reported that R6 had just used the nebulizer before they went outside. LPN “V” reported they were going to find a bag. A review of the medical record revealed R6 admitted into the facility on 3/7/2025 with the following medical diagnoses, Chronic Obstructive Pulmonary Disease and Obstructive Sleep Apnea. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental status score of 12/15, indicating an impaired cognition. R6 also required assistance with bed mobility and transfers. On 8/13/2025 at 2:05 PM, an interview was conducted with the Director of Nursing (DON). The DON reported they expected the nebulizer mouthpiece to be stored in a bag. R191 On 8/11/2025 at 3:09 PM, R191 was observed sitting in the hallway. Observed on R191's nightstand was a nebulizer machine and the mouthpiece lying flat on top of the nightstand table. The mouthpiece was not observed inside of a plastic bag and did not appear to be drying. On 8/13/2025 at 10:08 AM, R191 was observed asleep in bed. The nebulizer remained in the same condition as on 8/11/25. On 8/13/2025 at 10:05 AM, LPN A was asked R191's order for the nebulizer and stated, Every 12 hours. LPN A was asked how the nebulizer should be stored when not in use. LPN A stated, in a plastic bag. A review of R191's medical record revealed, R191 was admitted to the facility on [DATE] with diagnosis of Acute Respiratory Failure with Hypoxia. A review of R191's quarterly Minimum Data (MDS) set assessment dated [DATE] noted R191's with a severely impaired cognition. A review of R191's care plan noted, Focus: Resident has an impaired pulmonary/respiratory status related to respiratory failure and tracheostomy. Date Initiated: 04/20/2025. Goal: Resident will have reduced complications related to their altered pulmonary/respiratory status through next review. Date Initiated: 04/20/2025. Interventions: Administer medications as ordered. Observe for effectiveness and report adverse side effects to Physician . On 8/13/2025 at 1:00 PM, the Infection Control Nurse was asked the facility's expectation for the storage of nebulizer when not in use. The Nurse explained they are to be stored in a bag when not in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use. A review of the facility's policy tilted, Nebulizer dated 6/23/25 noted, Purpose: Small volume nebulizers convert liquid medication into a fine mist, allowing for the delivery of the medication deep into the lungs. Appropriate cleaning and storage techniques of small volume nebulizers decrease the risk of introducing bacteria into the airways, and reduces the potential of pulmonary infections . Cleaning:1. Twist open the nebulizer cup and dump out any residual remaining from treatment. 2. Rinse nebulizer cup and components with water. 3. Allow the nebulizer cup and components to airdry on a clean absorbent towel. 4. Once dry store the nebulizer cup and mouthpiece in a bag and label. 5. Replace nebulizer and tubing weekly per procedure .