

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2024
NAME OF PROVIDER OR SUPPLIER  Autumnwood of McBain		STREET ADDRESS, CITY, STATE, ZIP CODE  220 Hughston St MC Bain, MI 49657	

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)
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49302</p> <p>Based on interview and record review, the facility failed to ensure written information was provided to five Resident/Representatives (#3, #5, #76, #332, #333) of six reviewed for written notice of bed hold.</p> <p>Findings include:</p> <p>Resident #3 (R3)</p> <p>Review of R3's progress notes revealed the following:</p> <p>1/26/24 at 19:21 (7:21PM): .spoke with resident again about change in condition and possibly going to the hospital. Resident is having pain radiating across upper back . Resident agreed to go to hospital.</p> <p>1/26/24 at 19:45 (7:45PM): On call [provider] ordered hospital transfer d/t (due to) change in condition . resident left with EMS (Emergency Medical Services) at 1937 (7:37PM) .</p> <p>Review of the Clinical Census report revealed R3 was hospitalized from 1/26/24 through 1/29/24.</p> <p>Review of the Bed Hold Authorization form revealed the Resident/Responsible Party signature line read, per call w/ (with) [name of Resident's son]. No signature from the resident or resident representative was noted on the form.</p> <p>Resident #76 (R76)</p> <p>Review of R76's progress notes revealed the following:</p> <p>3/26/24 at 3:40PM: Resident's abd (abdomen) distended, c/o (complains of) being freezing yet hot to the touch with a fever .notified on-call provider of assessment and called EMS to transfer to [City] hospital .</p> <p>Review of the Clinical Census report revealed R76 was hospitalized from 3/26/24 through 3/29/24.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2024
NAME OF PROVIDER OR SUPPLIER  Autumnwood of McBain		STREET ADDRESS, CITY, STATE, ZIP CODE  220 Hughston St MC Bain, MI 49657	
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)		
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Bed Hold Authorization form revealed the Resident/Responsible Party signature line stated, no per son [Name]. No signature from the resident or resident representative was noted on the form.</p> <p>34568</p> <p>Resident #5(R5)</p> <p>A review of the Progress Notes in the EMR for R5 revealed the following:</p> <p>11/24/23 at 11:01 AM .instructed that res (resident) will need to transfer to ED (Emergency Department) to be dialyzed at this point because she has refused 3 treatments r/t (related to) illness .Dialysis center will notify ED of res needs. This RN (Registered Nurse) also phoned ED for nurse-to-nurse report and will send appropriate documents. [Facility Name] able to transport res to hospital.</p> <p>Review of the Clinical Census report revealed R5 was hospitalized from 11/24/23 through 11/27/23. The census revealed R5 returned to the facility.</p> <p>Review of the Bed Hold Authorization form revealed the Resident/Responsible Party signature line stated, no per [name of R5's son]. No signature from the resident or resident representative was noted on the form.</p> <p>Resident #332 (R332)</p> <p>A review of R332's Facility-Initiated Transfer for Nursing Homes form dated 11/28/23 revealed a transfer to the hospital for respiratory failure.</p> <p>R332's Bed Hold Authorization form revealed the Resident/Responsible Party signature line stated, no per [name of R332's son]. And dated 11/29/23. No signature from the resident or resident representative was noted on the form, nor was there proof this was mailed out to the resident or responsible party.</p> <p>Resident #333 (R333)</p> <p>A review of R333's Bed Hold Authorization form revealed the Resident/Responsible Party signature line stated, no per call with [name]. and dated 11/20/23. No signature from the resident or resident representative was noted on the form, nor was their proof this was mailed out to the resident or responsible party.</p> <p>On 4/17/24 at 12:30 PM, an interview was conducted with Accounts Receivable Manager F and the Nursing Home Administrator (NHA). Accounts Receivable Manager F confirmed that a written notice had not been issued. Accounts Receivable Manager F stated the bed hold policies were not signed because she informed resident representatives via telephone. The NHA acknowledged a system failure regarding the bed hold notifications.</p> <p>Review of facility policy titled, Bed Hold Policy revised 2/14/22 read, in part:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2024
NAME OF PROVIDER OR SUPPLIER  Autumnwood of McBain		STREET ADDRESS, CITY, STATE, ZIP CODE  220 Hughston St MC Bain, MI 49657	

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)
<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>.Resident or Responsible Party choosing to hold the bed during hospitalization must sign the bed hold agreement . Signed Bed Hold Agreements are to be made part of the Resident's Business File and back up for charges .</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2024
NAME OF PROVIDER OR SUPPLIER  Autumnwood of McBain		STREET ADDRESS, CITY, STATE, ZIP CODE  220 Hughston St MC Bain, MI 49657	
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)		
<p>F 0661</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49302</p> <p>Based on interview and record review, the facility failed to ensure a recapitulation of stay was completed for one Resident (#10) out of two closed records reviewed for discharge documentation.</p> <p>Findings Include:</p> <p>Resident #10 (R10)</p> <p>Review of R10's most recent Minimum Data Set (MDS) Assessment, dated 2/1/24, revealed admission to the facility on [DATE], with diagnoses including bipolar disorder, major depressive disorder, suicidal ideations, and post-polio syndrome (a condition that causes gradual muscle weakness and muscle loss). R10 was discharged from the facility on 3/28/24.</p> <p>Review of R10's EMR revealed no discharge plan or recapitulation of stay.</p> <p>On 4/17/24 at 9:39AM, an interview was conducted with Social Service Director G who confirmed no post-discharge summary or recapitulation of stay was completed because R10 discharged to a different skilled nursing facility. Social Service Director G stated that when a resident transfers to the same level of care, a recapitulation of stay is not needed.</p> <p>On 4/17/24 at 10:40AM, an interview was conducted with the Director of Nursing (DON). The DON verified no recapitulation of stay was completed for R10 because of her discharge location.</p> <p>Review of facility policy titled, Discharge Planning revised, 9/7/23 read, in part:</p> <p>.all planned discharges from the facility will have a completed Post-Discharge Plan and Summary completed by the IDT [interdisciplinary team] members which includes:</p> <ol style="list-style-type: none"> <li>i. A recapitulation of the residents stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.</li> <li>ii. A final summary of the resident's status, at the time of discharge, that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative.</li> <li>iii. Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).</li> <li>iv. A Post-Discharge Plan and Summary, that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), who will assist the resident to adjust to his or her new living environment. The Post-Discharge Plan and Summary must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services .</li> </ol>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2024
NAME OF PROVIDER OR SUPPLIER  Autumnwood of McBain		STREET ADDRESS, CITY, STATE, ZIP CODE  220 Hughston St MC Bain, MI 49657	
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)		
<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34568</p> <p>Based on observation, interview, and record review the facility failed to employ sufficient staff with the appropriate competencies and skills to carry out the functions of the food and nutrition services. Findings include:</p> <p>On 4/15/24 at 9:55 a.m., an interview was conducted with Dietary Cook (Staff) H about her certification as a dietary manager. Staff H stated she had not completed the Certified Dietary Manager's (CDM) course work and believed that Dietary Cook (Staff) I had more interest in becoming the CDM for the facility. Staff H stated that a CDM from another facility was helping them with keeping track of weights of residents.</p> <p>On 4/16/24 at 11:30 a.m., Staff I was noted to be serving the main dining room lunch which was tacos, refried beans, mixed vegetables, ham and potato casserole, mashed potatoes, and gravy. It was observed that the tacos were pre-made in the soft shell and Staff I could not bring the tacos up to temperature of 135 degrees Fahrenheit. Staff I was observed taking a taco out of the steam table, placing it on a used heating pad and placing the thermometer on top of the meat. Staff I then took the same taco and placed it directly onto the steam metal table to attempt to read another temperature. Staff I stated that the tacos were not the correct temperature, placed the taco back into the warming pan, and put the tacos back into the oven.</p> <p>Due to complaints from residents of small portions, Staff I was asked to read the serving size scoops to this Surveyor. It was discussed that the ham and potato casserole used as the alternative meal was being served with a 4-ounce (oz) scoop. When asked how Staff I knew that this was the correct measuring device, she stated, We use basic principle, since the taco meat is supposed to be 3 oz, we go a little more with the alternate, so it [NAME] out. A request was made to review the production menu for the ham and potato casserole.</p> <p>Review of the production menu for the ham and potato casserole on 4/16/24 at approximately 1:30 p.m. revealed the correct serving size was 6 oz. An interview was conducted with the Nursing Home Administrator (NHA) who confirmed that he had no full time CDM at the facility.</p> <p>On 4/17/24 at 11:30 a.m., Dietary Aide (Staff) J was observed serving the lunch meal in the main dining room. This lunch consisted of macaroni and cheese, barbeque chicken, collard greens, ham and potato soup, deli sandwich, mashed potatoes, and gravy on the main steam table. When asked to read the serving scoop sizes, Staff J stated that the collard greens were a 2 oz scoop.</p> <p>A review of the production menu for the 4/17/24 lunch meal revealed that the correct serving size for collard greens was 4 oz.</p> <p>49302</p> <p>During the initial tour of the facility on 4/15/24 at 10:44AM, an interview was conducted with R234. R234 stated portion sizes were small, and he often remained hungry at the end of meals.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/17/2024
NAME OF PROVIDER OR SUPPLIER  Autumnwood of McBain		STREET ADDRESS, CITY, STATE, ZIP CODE  220 Hughston St MC Bain, MI 49657	
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)		
<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>49397</p> <p>Resident #25 (R25)</p> <p>On 4/15/24 at 5:30 PM, an interview was conducted with R25's resident representative (RR) C who stated the food in the facility was horrible. RR C stated when he had visited R25 recently during dinner, the fish sticks were hard enough you could have used them to drive a nail into something. RRC stated the potatoes were undercooked and hard and that food was often over or undercooked. RR C stated when visiting R25 during meals, food portions often varied, further explaining on one particular occasion R25 received only half of a bratwurst for a meal.</p>		