STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235446	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumnwood of Deckerville	3387 Ella St Deckerville, MI 48427

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 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation pertains to Intake Number MI00145606. Based on observations, interviews and record review, the facility failed to protect Resident #2's right to be free from sexual abuse by Resident #1 for one resident (Resident #2) of four residents reviewed for abuse, resulting in Resident #1 being observed to make non-consensual contact with Resident #2's perineal area, with a finger in Resident #2's brief, while Resident #2 was lying in bed, resulting in psychosocial harm, trauma and/or fear using the reasonable person concept and the potential for injury. Findings include: Resident #1: A review of Resident #1's medical record revealed an admission into the facility on [DATE] with diagnoses that included stroke, depression, anxiety disorder, adjustment disorder with depressed mood, cognitive communication deficit and intracranial injury. A review of the Minimum Data Set (MDS) assessment revealed the Resident had a Brief Interview of Mental Status (BIMS) score of 15/15 that indicated intact cognition, functional limitation in range of motion with impairment on one side of upper and lower extremity. Further review of the medical record revealed the Resident had a Guardian as the responsible party. On 7/22/24 at 11:55 AM, an observation was made of Resident #1 sitting in his wheelchair in his room. The Resident's hair was disheveled, not combed/brushed and had long facial hair. The Resident was dressed. The Resident was interviewed, answered some simple questions, was difficult to understand, and wandered off topic to talk of his brother. The Resident indicated he could not move his right arm, that was positioned on the side of his thigh, but reported he could move his wheelchair on his own and the Resident moved the wheelchair back from where he was originally seated in his room. After leaving Resident #1's room, an observation was made of Resident #2's room that was down the hall towards the nurses' station and down another hall a short distance from the nurses' station. A review of Resident #1's medical record revealed the following progress notes: (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Dated 6/6/24 at 11:08 AM, .3 episodes of yelling with abusive language toward caregivers and 2 episodes of physical aggression toward care givers past week per behavior monitoring log. Individual interventions utilized once and effective per behavior monitoring. Occasional episodes of anger and frustration per nursing notes. He was noted to become angry about his mechanically altered diet and threw his plate on the floor in the dining room [ROOM NUMBER]/3/24 . -Dated 6/28/24 at 8:31 AM, Cena (certified nursing assistant) staff observed resident inside a female room today-he was observed self propelling his wheelchair toward her bed. He has been advised not to be allow in this female resident room several times in the past, but he keep going into her room daily per staff reporting to me. Will continue to monitor. He was taken out of her bedroom into his room and advised that he is not allow in any female room unless is consented. -Dated 6/28/24 at 17:45 (5:45 PM), Behavior Note, Cena staff came to me to report that resident was observed again in the same prior female room than earlier. He was right by her bed side. He was again told that he was not allowed to be in there, and resident got angry and preside to cuz (cuss) f* you B*s, and preside to spit at staff in rage. Staff removed him from her room. -Dated 6/28/24 at 19:45 (7:45 PM), Nurses Notes, Resident was observed sitting at another resident's bedside with hand on brief. Resident was immediately removed from room and return to his room. At this time the resident will be placed on 1 on 1 supervision while awake. Per Resident #1's medical record, the Resident had a room change from room [ROOM NUMBER]-B to room [ROOM NUMBER]-B. Resident #2 resided in room [ROOM NUMBER]-A. Resident #2: A review of Resident #2's medical record revealed an admission into the facility on [DATE] with diagnoses that included epilepsy, dementia, anxiety disorder, weakness, hypoxic ischemic encephalopathy and anoxic brain damage. A review of the MDS assessment revealed the Resident had severely impaired cognitive skills, had functional limitation in range of motion with impairment of bilateral upper and lower extremity, and was dependent for activities of daily living and transfers. On 7/22/25 at 12:02 PM, an observation was made of Resident #2 positioned in a Geri-chair, that was reclined, propelled by staff to her room. On 7/22/25 at 12:09 PM, an observation was made of Resident #2 lying in bed with her eyes closed. The Resident did open her eyes when her name was called but did not make eye contact or acknowledge surveyor was in the room. The Resident was covered with a light blanket. Her hands and arms were bent, arms close to her body, fingers bent towards the palm of her hand with two fingers out straight and ridged on one hand. The Resident did not communicate with the surveyor. A review of Resident #2's progress notes in the medical record revealed the following: -Dated 6/28/24 at 14:35 (2:35 PM), Social Services Note, Spoke with father/Guardian (Name) and informed him a male resident has brought (Resident #1's name) flowers and attempted to visit her in her room. The staff have been redirecting the male resident away from (Resident #2's name) room. Her father expressed appreciation at redirecting the male resident and asks the staff continue to do so. (Resident #2's name) has exhibited no s/s (signs/symptoms) of distress. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Dated 6/28/24 at 21:42 (9:42 PM), Behavior Note, I was notified at 1945 (7:45 PM) that (Resident #2's name) had Resident (#1's initials) sitting at her bedside with his hand on top of her brief. (Resident #2) was reported to be sleeping and did not wake up. Social Services made aware. When arriving at the building the resident still remains asleep with no psychosocial distress noted or reported from staff. Will continue to observe. A review of the facility's report of incident revealed the following: -Date of incident: 6/28/24 -Time of incident: 7:45 PM -Reported Incident: At 19:45 PM (7:45 PM) resident (#1's name) was witness in resident (#2's name) room. He was observed by the charge nurse sitting next to her bed with his hand on top of her brief. The witness stated that he had a finger partially present in the brief by her thigh. Resident (#2's name) was asleep when this was observed and did not wake up. The nurse immediately separated the two residents and resident (#1's name) was returned to his room and placed on 1 on 1 supervision. Legal parties were notified along with physician at time of incident. -Interviews: Nurse A: Interview completed with (Nurse A). She stated that at approximately 1945 PM she entered room [ROOM NUMBER]-A. Upon entering the room she noted that resident (#1) was sitting next to Res. (#2)'s bed. He was sitting on the left side of her bed with his wheel chair next to the bed. Resident is flaccid on right side and only has control of his left side due to hemiparesis form TBI (traumatic brain injury). When (Nurse A) entered the room she noted that he was sitting parallel to Res. (#2). Her blanket/sheet was only partially on her. She was lying in bed with her legs spread apart; which is typically for Res. (#2) related to her spasticity from her anoxic brain injury. Resident (#1) had his left hand by (Resident #2)'s left thigh with his index finger in her brief. Res. (#2) was asleep at the time and did not wake up. (Nurse A) immediately separated the two residents. (Resident #1) became upset with (Nurse A) and began calling her a liar. CNA (Certified Nursing Assistant) C: Interviewed (CNA C) about the incident from 6/28/24. (CNA C) stated that his interaction with (Resident #2) occurred after the incident. He stated that he helped him into his room, and getting him ready for bed. He stated that he was saying the word finger and pussy. But was very difficult to understand, and (CNA C) stated that it was difficult to tell if he was stating to him what he was accused of, or what he did . CNA B: Interviewed (CNA B) in regards to incident on 6/28/24. (CNA B) stated that she had been his assigned CNA that shift (7 a-7). She stated that (Resident #1) had made approximately 2 attempts to go into (Resident #2's) room and visit with her. Each time he was intercepted and redirected. (CNA B) stated that they told him he could not visit with her in her room, but that they would bring her out in a public area if he would like to visit. He would become upset and was yelling Fuck Autumnwood and it's my right. (CNA B) stated he was becoming agitated and spitting and yelling at the staff. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	-Investigation Conclusion: At 19:45 PM resident (#1) was witnessed in resident (#2's) room. He was observed by the charge nurse (Nurse A) sitting next to her bed [parallel] with his hand on her left thigh by her brief area. (Nurse A) also stated he had his left index finger inserted in her brief. Her brief remained intact. Resident (#2) was asleep when this was observed and did not wake up. The nurse immediately separated the two residents. (Nurse A) was attempting to explain to him that he could not be in the room and the resident grew increasing upset and started to yell at the nurse calling her a liar. The resident was removed back to his room. (Resident #2) remained asleep and had no signs of any psychosocial harm . On 7/22/24 at 1:23 PM, an interview was conducted with Social Service (SS) D regarding the incident between Resident #1 and Resident #2 on 6/28/24. The SS was queried regarding Resident #2's communication with others and the SS reported Resident #2 was a vulnerable adult, she can make eye contact, she can let you know her basic needs by yelling out, grunts and groans, and say yes and no. The SS indicated that after the incident occurred, he had been notified of the incident, came into the facility that night, had seen Resident #2, reported Resident #2 had been sleeping, had not woken her up, and covered the first one-to-one shift with Resident #1. The SS was asked about Resident #1 in contact with Resident #2 prior to the incident on 6/28/24 when witnessed at Resident #2's bedside with his hand on her brief and a finger inside the brief. The SS stated, Multiple times he (Resident #1) tried to engage with (Resident #2), and reported another day when Resident #1 was in Resident #2's room. The SS reported he had told Resident #1 that he could not go into her room. When asked about Resident #1 giving a flower to Resident #2 on 6/28/24, the SS reported the Resident had gone out to the courtyard and picked the flowers. The SS reported he had contacted Resident #2's guardian who did not want her alone with Resident #1. The SS reported that when Resident #1 had gone into Resident #2's room before, they had changed Resident #1's room further away from Resident #2's room. A review of Resident #1's census revealed a room change on 6/19/24 from room [ROOM NUMBER] to 106. The SS reported that Resident #1 was angry when we removed him from her room and stated, We wanted to try and keep everyone safe and told him he could not be in her room, when asked why they were alerted to change his room, the SS stated, (Resident #2) was a vulnerable individual and we were trying to prevent him from going into her room. The incident on 6/28/24 was reviewed with the SS. A review of the Resident witnessed with his finger inside her brief, the SS reported that was all they knew had happened and reported they can't go with anything but the facts, we don't know what happened prior but that he was witnessed with his hand on her brief and a finger inside the brief. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 7/22/24 at 2:02 PM, CNA B returned a phone call and was interviewed regarding the incident between Resident #1 and Resident #2 on 6/28/24. The CNA reported she had assigned care of Resident #1 on 6/28/24. The CNA indicated that Resident #1 had made attempts to keep going down to Resident #2's room that day and stated, We had to keep an eye on him. The CNA reported that Dietary staff had brought trays down and said he was in her room, and they had gotten a CNA to go down there and take him out. We were all watching, and he tried multiple times to go down there. The CNA stated, at 6ish he was going into her room, and he got very irate, screaming at me, that it was his right to go down there. The CNA reported she explained it was Resident #2's right for privacy and reported Resident #1 got really upset, swearing at me, started spitting in my face. The CNA reported that she took him out of the room to the Nurse (Nurse A) and told her what happened and left Resident #1 with the nurse. The CNA stated, I was told the next day about it. I heard that he was caught in her room with his hand in her pants. The CNA was asked about Resident #1's interactions prior with Resident #2. The CNA indicated Resident #1 had given Resident #2 a flower and Resident #2 had responded with a smile. When asked if Resident #2 followed simple commands, the CNA stated, Not very well. When asked how Resident #2 communicated, the CNA reported that given time the Resident could give out a short response and reported she hollers out. When questioned about Resident #1's interactions with other Residents, the CNA indicated Resident #1 was not very social person, keeps to himself, had tried one other time with her (Resident #2), passed out [NAME] to staff and to her (Resident #2). On 7/22/24 at 2:52 PM, an interview was conducted with the Administrator (NHA) regarding the incident on 6/28/24 when Resident #1 made sexual contact with Resident #2. The NHA indicated that the Nurse had contacted her immediately and she had come in to get interviews with the people at the facility. When asked if she was aware of multiple attempts of Resident #1 in contact with Resident #2, the NHA stated, Yes, and reported that Resident #1 verbalized that he for any reason, they were very similar, he was in the situation that she was in and felt connected to her, he felt bad for her and wanted to visit with her. The NHA reported that Resident #1 had been in her room before and we had switched his room and moved Resident #1 further from Resident #2. Resident #1 with a history of being in Resident #2's room prior, had multiple attempts to get into Resident #2's room the day of the incident and had emotional outburst with the CNA prior to the incident was reviewed with the NHA. The NHA indicated that Resident #1 had been put on one-to-one staffing to resident but reported had not had any other incidents and had been taken off the one to one. When asked about a lack of documentation of a skin assessment after the incident, the NHA stated, I am sure they did but just didn't document it. Resident #1 was witnessed with a finger in Resident #2's brief and was not witnessed until this point was reviewed with the NHA. The NHA stated, don't really know what happened prior to being discovered, and reported the Nurse should have done and document a skin assessment. When asked about the time period that the Resident #1 was not visualized by staff when he had entered Resident #2's room, the NHA was unsure and reported Nurse A had gone into the nutrition room to talk to a CNA, when they were done, Resident #1 was not insight and she went down there to check Resident #2's room and Resident #1 was in her room and prior to that Resident #1 had been brought to the dining room for dinner after the incident with CNA B. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of the facility policy titled Abuse Prohibition Policy, effective 10/14/22, revealed, Policy: Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse . To assure guests/residents are free from abuse, neglect, exploitation, or mistreatment, the facility shall monitor guest/resident care and treatments on an on-going basis. It is the responsibility of all staff to provide a safe environment for the guests/residents . Sexual Abuse is non-consensual sexual contact of any type with a guest/resident. Sexual abuse is defined as non-consensual sexual contact of any type with a guest/resident. Sexual abuse includes, but is not limited to: unwanted intimate touching of any kind especially of breasts or perineal area . C. Prevention: .8. Staff will be instructed to report any signs of stress from family and other individuals involved with the guest/resident that may lead to abuse . and intervene as appropriate .