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	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumnwood of Deckerville	3387 Ella Street 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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Number 1316000. Based on observation, interview and record review, the facility failed to provide adequate supervision, ensure comprehensive investigations of falls, and implement meaningful interventions to prevent falls for two residents (# 701 and #702) of three residents reviewed, resulting in falls with injury including nasal bone fractures, the necessity for emergency medical treatment, and unnecessary pain. Findings include: Resident #701:On 8/6/25 at 12:30 PM, Resident #701 was observed in their room in bed with their eyes closed in the locked dementia unit of the facility. The Resident's call light was next to the Resident's bed and not within easy reach.Record review revealed Resident #701 was admitted to the facility on [DATE] with diagnoses which included mood disorder, major depressive disorder, anxiety, and dementia. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required set up to moderate assistance to complete Activities of Daily Living (ADLs) including supervision/touching assistance with ambulation.An interview was completed with Registered Nurse (RN) A on 8/6/25 at 12:45 PM. When queried regarding Resident #701, RN A revealed the Resident was in the locked dementia unit because they are very confused and had even tried to break windows and doors to get out. With further inquiry, RN A revealed the Resident has a court appointed guardian. RN A was asked if Resident #701 had any falls while at the facility and stated, Yes, when they first got here. When queried if the Resident was injured from the fall, RN A responded that they had two black eyes. When asked if they were working when Resident #701 fell, RN A responded they were not.At 2:00 PM on 8/26/25, Resident #701 was observed in their room in bed.Review of Resident #701's Electronic Medical Record (EMR) revealed a care plan entitled, (Resident #701) is at risk for fall related injury and falls R/T (related to): Dementia (Created and Initiated: 5/1/25). The care plan included the interventions:- Encourage the resident to wear appropriate footwear as needed. Replace resident's worn out shoes r/t incident 5/4/25 (Created and Initiated: 5/1/25; Revised: 7/18/25)- Keep the resident's environment as safe as possible with: even floors free from spills and/or clutter; adequate lighting; call light within reach, commonly used items within reach, avoid repositioning furniture and keep the bed in the appropriate (Created and Initiated: 5/1/25)- Provide resident with activities that minimize the potential for falls while providing diversion and distraction (Created and Initiated: 5/1/25)- Put the call light within reach and encourage her to use it for assistance as needed (Created and Initiated: 5/1/25)A second care plan entitled, (Resident #701) has a functional ability deficit and requires assistance with self-care/mobility R/T: dementia (Initiated and Revised: 5/1/25). The care plan included the intervention, Ambulation/Walking: Resident Supervision/touching assist with one helper (Initiated and Revised: 5/1/25).Review of Resident #701's Nursing Comprehensive Evaluation dated 5/1/25 at 1:54 PM revealed the Resident was at risk for falls.Review of skin assessment documentation in Resident #701's EMR revealed no documentation of facial bruising.Further review of Resident #701's EMR revealed the following progress notes:- 5/4/25 at 3:15 AM: Nurses Notes. Resident came to nurse's station and stated, 'I think I fell'. Resident's mouth was bleeding and resident had blood on their hands. Resident was assessed and neuros initiated. Swelling and bruising noted to nose and lower lip. Resident's face and hands were cleansed of blood and upon changing resident's clothing noted resident's shoes were worn and rubber soles were peeling back at the toe area. Resident also c/o (complain of) left knee pain. Noted small abrasion to lateral side of patella and slight bruising to medial side. Care plan updated with intervention to replace resident's worn shoes. Just prior to incident had been observed ambulating towards dining room. Upon this writer's investigation of incident resident was asked what happened and replied, I was chasing the dogs'. This writer and CNA (Certified Nursing Assistant) noted blood on dining room floor and chair shortly after incident.- 5/5/25 at 11:52 AM: Nurses Notes. Facial bruising to both orbits, chin, and swollen bottom lip.- 5/6/25 at 5:49 PM: Nurses Notes Day 3 of incident/fall. Resident has no injuries. has bruising surrounding eyes, but does not complaint of pain. complained that lip was sore, which it is swollen.- 5/8/25 at 11:16 AM: Resident At Risk. being reviewed by the IDT r/t incident that occurred on 5/4/25. shoes were worn with a floppy bottom and where removed and gripper sock provided until new shoes are purchased.- 5/23/25 at 9:15 AM: Psychiatry Follow up -history of Alzheimer's disease dementia with agitation. recent fall with facial bruising .On 8/7/25 at 9:55 AM, Resident #701 was observed standing in the dining/activity room of the locked dementia unit with staff present providing touching assistance. The Resident was wearing sweatpants. The sweatpants were long, and the Resident was walking on the pants with the heel of their