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	04/22/2026

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to fulfill residents' rights by ensuring that 1) Call lights were in reach, 2) Vital signs and medications were administered/performed during the lunch time meal in the dining area with care plans not individualized, 3) Nail care was performed routinely, 4) Sanitary storage of urinals, and 5) Personal medical records were protected for 4 residents (10, 18, 56, and 58) of 8 residents reviewed for dignity, activities of daily living and residents observed during dining observation.Findings include:Resident 10 (R10):On 4/20/26 at 9:26 AM, an interview was conducted with R10, who was lying down on his bed with the head of the bed elevated. The Resident was asked questions but answers were unreliable and the Resident engaged in limited conversation. When asked about their call light, the Resident was unsure where it was at but looked for it. The call light was positioned on the chair next to the resident's head of the bed with a shoe positioned on top of it. The Resident was asked if he could reach it, but the Resident was unable to see or find the cord to get to the call light. On 4/20/26 at 9:45 AM, staff were observed in the hallway and were directed to R10's room due to the call light not in reach of the Resident. The Staff positioned the call light across the resident and ensured the call light was in reach for the resident and knew where to find it.Resident 18 (R18):On 4/21/26 at 10:02 AM, an observation was made of R18 dressed and sitting in his wheelchair. The Resident was interviewed, answered questions and engaged in conversation. An observation was made of his fingernails on the left hand with long fingernails. The right hand had contractures and the resident was unable to open his hand. The fingernails were long and the 5th digit was curled in and was not able to be visualized. When asked if staff offer to trim his nails, the Resident reported he could not see them and did not know if they needed to be trimmed but indicated they have offered before. When asked if they offered during his last shower, the Resident stated, No, they didn't the last time. Resident 56 (R56):On 4/20/26 at 1:00 PM, an observation was made of R56 lying in bed. The Resident was interviewed, answered simple questions and engaged in limited conversation. An observation was made of R56's fingernails with some of them being long and/or jagged. When asked how he liked the length of his nails, the Resident reported he liked them shorter than what they were and stated, I don't like them to be this long. If I catch it on something they bend backwards, and indicated that was painful. When asked if staff had offered to trim them with his last shower, the Resident stated, They told me they could not find the clippers to cut them. Two nails were down to the skin. The Resident was asked if those nails had broken. The Resident stated, I chewed them off to get them shorter. Resident 58 (R58):On 4/20/26 at 12:45 PM, an observation was made of R58 sitting in a wheelchair in their room. The Resident was interviewed, answered questions and conversed in conversation. An observation was made of the Resident's urinal positioned on the overbed table with oxygen tubing curled up underneath the urinal and snack food near the urinal. The urinal was observed to have residual urine in the container. Another urinal was positioned on top of the heart rhythm transmitter equipment and a stack of newspapers. Nurse C came in to do vital signs and had mentioned the stack of papers to the Resident but did not remove the urinal positioned on the papers and transmitter equipment nor remove the urinal on top of the bedside table. The Resident was asked about a urinal holder and the Resident (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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported that he does not have one but reported the staff were good about emptying them when needed. Dining Observation:On 4/20/26 at 11:22 AM, observations were made during the lunchtime meal that was served in the main dining room. An observation was made of Nurse C passing medication to Resident #56 who was sitting at a table with other residents. There were other residents at tables in the vicinity. An observation was made of the Nurse with the medication cart outside the dining area in the hallway. The Nurse was observed to be giving Resident #51and Resident #44 medication in the dining area during the lunchtime meal. An observation was made of Nurse C taking the vitals of Resident #62 who was seated at a table with other residents and was assisted with her meal by a staff member.On 4/20/26 at 11:43 AM, during the lunchtime meal observation, the medication cart in the hallway was observed to have a Resident's information up on the screen of the computer. No staff were at the medication cart, as the Nurse was in the dining area passing medications to a Resident. There were Residents in wheelchairs propelling themselves near and past the medication cart with the Resident information displayed on the screen. On 4/22/26 at 9:57 AM, an interview was conducted with the Director of Nursing (DON) regarding the care planned intervention in multiple resident medical records of the intervention May administer medications in common areas. The DON reported that it was an intervention that would be put in automatically for all residents. When asked if it was discussed with the resident or representative, the DON reported that if they did not like it, they could ask not to have medication administered in the dining area. The DON reported no documentation for discussion on the intervention. It was reviewed of the lack of individualized care planning. On 4/22/26 at 1:33 PM, an interview was conducted with Unit Manager, Nurse J . The Nurse was asked about passing medication during the lunchtime meal and reported the Nurse was passing 11:00 and 12:00 medications at that time. It was reviewed of the lack of individualized care planning with an intervention for passing medications in a common area. The Nurse reported that the nurse would be able to pass the medication an hour before or an hour after the scheduled time. When asked about protecting health information while passing medication, the Unit Manager reported either locking the screen, tilting the screen down or minimizing the screen. An observation was made of Resident #58 urinal on the bedside table, lying on top of personal items and near their cup of water. The UM indicated to the Resident the urinal could go into a urinal holder instead of being stored on top of the overbed table. The Resident reported he would appreciate that. An observation was made with the Unit Manager of Resident 18's fingernails with the left hand well trimmed and the right hand had been trimmed but continued to have some length to them and jagged. The Unit Manager indicated that they seemed sharp and they should be filed. The Unit Manager reported that they had emery boards available and stated, clippers are always available.When asked about facility policy for nail care, the Unit Manager reported they should be offered nail care with showers or as needed, not everyone needs their nails trimmed twice a week, but if the resident wanted them trimmed, they should be done. A review of the facility policy titled, Call Lights, revealed, Policy: Call lights will be placed within the resident's reach and answered in a timely manner. Procedure: .3. When a resident is in bed or confined to a chair ensure the call light is within easy reach of the resident.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain informed consent prior to providing a psychotropic medication for one resident (Resident #71) of 5 residents reviewed for medications. Findings Include: Resident #71: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #71 was admitted to the facility on [DATE] with diagnoses: Alzheimer's dementia, history of a stroke, psychosis and adjustment disorder. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss with a Brief Interview for Mental Status/BIMS score of 0/15 and needed some assistance with care. A review of the Care Plans for Resident #71 identified the following: (Resident #71) has an actual behavior problem r/t (related to): Alzheimer's dementia, with progression of dementia, (Resident #71) has been exhibiting an increase in psychosis with delusional though process. He has been exhibiting an increase in anger, agitation and aggression. date initiated and created 10/16/2025 and revised 1/20/2026 with Interventions including: Administer medication as ordered. Observe for ineffectiveness and side effects. initiated and created 10/24/2025. A record review of the progress notes for Resident #71 revealed the following: 3/11/2026 at 11:45 AM, a Psychiatry Follow up note, . Evaluation of Xanax for showers. At the last visit, Ativan was discontinued due to ineffectiveness, and he was switched to Xanax 0.5 mg prior to showers. He did accept 1 shower on 2/20/2026, but he has refused every shower since then. A record review of the physician orders for Resident #71 identified an order dated 2/12/2026, Xanax oral tablet 0.5 mg, Give 0.5 mg by mouth on shower days, start date 2/16/2026. A review of the Psychotropic Medication Informed Consent documents for Resident #71 identified an informed consent for Ativan (anti-anxiety medication) dated 1/4/2026, but there was no informed consent document for the Xanax (anti-anxiety medication) started on 2/16/2026.On 4/21/2026 at 4:12 PM, Social Worker A was interviewed about the psychotropic medication consents for Resident #71. Upon review of the resident's medical record, Social Worker A identified there was no consent for Xanax for Resident #71. He said the resident previously received Ativan and then it was changed to Xanax. A consent for Ativan was identified and Social Worker A said there should have been a consent for Xanax also. The Social Worker A said the nurses obtained consent on admission for the psychotropic medications and the Social Worker followed up with consents for changes in medications and when the Psych group made recommendations. A review of the facility policy titled, Psychoactive Medication Management, origination date 7/1/2014 and last approved 1/28/2026 provided, Policy: The facility will provide individualized care and services that promote the highest practicable level of function by providing activity/functional programs as appropriate and safety interventions. Residents receiving psychoactive medications to teat behavioral symptoms are evaluated, monitored, and managed by the interdisciplinary team. Residents receiving psychoactive medications upon admission, those with new psychoactive medication orders or an increase in the dose of the medication, will have a psychotropic medication informed consent completed. Before initiating or increasing a psychotropic medication, the resident family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medication, in advance of such initiation or increase.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise care plans regarding advance directives for three residents (R5, R82, R83) of three residents reviewed for advance directives. Findings include:Resident #5: R5 is [AGE] years old admitted to the facility on [DATE] with diagnoses that include type 2 diabetes, depression, chronic kidney disease and congestive heart failure. On 04/20/2026 at11:36AM, record review revealed a signed do not resuscitate (DNR) form dated 11/7/25 and a physician's order for a DNR. Record review revealed a care plan that indicates R5 is a full code and it is dated 9/15/25. Resident #82: R82 is 87 years and is discharged from the facility. On 04/21/2026 at 12:31PM, record review revealed a physician's order for a DNR, dated 2/13/26 and a signed document dated 2/18/26 that indicates that R82 has chosen to be a DNR. The care plan for advance directives indicated R82 was a full code, dated 1/21/26. SW was made aware that the care plan for the closed record was not correct. Resident #83: R83 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include cellulitis of the right lower limb, heart disease, depression and chronic obstructive pulmonary disease. On 04/21/2026 at 9:26AM, record review revealed a physician's order for a full code and a signed document indicating that R83 had elected to be a full code. Record review revealed that there is no care plan present in the chart for advance directives. On 04/21/2026 at 1:36PM, an interview was conducted with Social Work (SW) A. SW A was asked if they do care plans for advance directives. SW A stated, yes, I do and the nurses do too. SW A was asked who updates the care plans for advance directives if there is a change. SW A stated. I can update them and the nurses can as well. If I am the one getting the code status change then I should be the one updating that care plan. SW A was asked if advance directive care plans are done on admission for baseline care plans. SW A stated, yes, they are done on admission. SW A was made aware that there was no care plan present for advance directives for R83 and that the advance directive care plans for R5 and R82 were inaccurate. SW A stated, I thought I got this one put in for R83, but clearly, I didn't. I will correct all of them right now. Review of the policy titled, Advance Directives- Michigan, revealed: Refusal of Treatment All residents have the right to refuse treatment at any time, including life-sustaining treatment. Any person authorized to act on behalf of the resident may also refuse care or treatment on behalf of the resident. D. Care Plan The care plan should be reviewed and revised to address refusals of care and the withholding and withdrawing of treatment, as appropriate.

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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 observation, interview and record review, the facility failed to ensure that assessment, monitoring and treatments were completed/administered for two wounds on the left forearm and one wound on the right forearm for one resident (Resident #10) of one resident reviewed for wound care.Finding include:Resident #10:On 4/20/26 at 9:26 AM, an interview was conducted with Resident 10 (R10) who was lying in bed. The Resident was asked questions, but answers were unreliable and the Resident engaged in limited conversation. An observation was made of a large bandage on the Resident's right wrist area with a date of 4/15 and the resident had two bandages on the left arm that were not dated. All three bandages had blackened areas where it looked like they had bled into the bandage and dried. When asked why he had bandages, the Resident reported they kept bleeding. The Resident was not sure when the staff had put on the bandages on the left arm and stated, They put those on quite a while ago, and indicated it was not today.A review of R10's medical record revealed the Task: Shower/Bathing revealed Question 1: Skin Observation, dated 4/18/26 and 4/21/26, had the area None of the above observed that indicated no skin issues were observed. There was an area for Skin Tear to be documented.A review of the document titled Skin Check was dated 4/21/26 at 3:02 AM, revealed the following: 1. Skin Check: .8. No skin issues (was indicated) .13. No new skin issues found on this evaluation (was indicated) .A review of the progress notes for R10 revealed a lack of documentation on 4/15/26 of a wound to the right wrist area and a lack of documentation of wounds to the left arm.On 4/21/26 at 4:03 PM, an interview was conducted with the Unit Manager, Nurse J regarding the bandages on R10's arms. The Resident was sitting near the nurses' station, and an observation was made of the bandages on the right and left arm. The Resident had one bandage on the right arm that was dated 4/15 and the other bandages were not dated. The Unit Manager reported that the Resident often got skin tears on his arms and the band aids should be changed daily. The one bandage was dated 4/15 and the other bandages were not dated. The Unit Manager reviewed the treatment record and was unable to determine when the other band aids were applied. The Unit Manager was asked about an assessment and documentation for the areas. Upon review of the medical record, there was a lack of documentation regarding what occurred and lack of assessment. A review of the orders revealed a lack of a treatment and monitoring criteria for the wounds to the bilateral arms. Nurse I who was assigned care of R10 removed the bandages from the left arm, cleansed the area and reported they appeared to be skin tears. An observation was made of the Resident flinching as the bandage was removed from the right hand. Nurse I reported that the adhesive of the band aids was not good for the resident's skin, the resident's skin was fragile, and a wrapped would be more appropriate for the Resident. The wound on the right wrist area was reddened and moist under the bandage. The Nurse reported she would clean the area and apply triple antibiotic ointment to the area. The Unit Manager reported that an order for treatment and monitoring would be put into the medical record and the treatment would show on the treatment administration record to be changed and monitored daily.Nurse I was asked if she was aware of the wounds and she indicated she was not aware. When asked if it was passed on in report, the Nurse reported that information had not been exchanged. When asked if there were new skin issues or wounds, should that be passed on from nurse to nurse in report, and the Nurse indicated that was information that should be relayed to the oncoming Nurse.A review of facility policy titled, Skin Management, revealed, . Overview: Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing. On going monitoring and evaluation are provided to ensure optimal resident outcomes. Practice Guidelines: .11. A skin check evaluation is completed for each resident by the licensed nurse weekly. The licensed nurse will document findings on the skin check evaluation. The CNA/STNA will report any new skin impairment to the licensed nurse that is identified during daily care. 12. If a new area of skin impairment is identified, notify the resident, responsible party, practitioner, DON/designee and treatment team, if (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	applicable. Treatment of Skin Tears: A skin tear is an opening or break in the skin due to friction, shear or trauma and is technically a separation of the epidermis and dermis. All skin tears will be evaluated, documented and treated based on physician's orders. Guidelines: 1. Upon occurrence, all skin tears will be reported to the licensed nurse. 2. An incident and Accident Report is to be completed. 3. The licensed nurse is responsible for documenting skin tears upon occurrence and monitoring on a weekly basis until healed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide necessary management and care of an indwelling urinary catheter for 1 resident (Resident #47) of 3 residents reviewed for urinary catheters. Findings Include: Urinary CatheterResident #47: A review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #47 was admitted to the facility on [DATE] with diagnoses: Dementia, heart disease, diabetes, chronic kidney disease, anxiety, history of bladder inflammation with bleeding, surgically placed supra pubic urinary catheter (a catheter inserted through the abdomen into the bladder). The MDS assessment 3/30/2026 revealed the resident had moderate cognitive loss with a Brief Interview for Mental Status/BIMS score of 8/15 and the resident needed assistance with care.On 4/21/2026 at 9:34 AM, Resident #47 was observed lying in bed awake. A urinary catheter bag was observed sitting on the floor; a blue cloth cover was half over the catheter bag. The resident was asked about the catheter and said she'd had it for a while. A review of the physician orders for Resident #47 identified the following: SP (suprapubic) Care q (every) shift. Cleanse with normal saline and apply drain sponge every day shift, start date 3/24/2026. Change SP catheter 22 Fr, 10cc balloon every night shift every 28 days, start date 4/9/2026. A review of the progress notes for Resident #47 provided the following: 4/2/2026 at 4:58 PM, Nurses Notes Resident has few pinpoint dark blood clots throughout her SP catheter tubing. Cranberry juice has been encouraged this shift. 3/30/2026 at 2:02 PM, Nurses Notes Resident yelling help from her room. Entering observed resident's foley catheter bag detached with urine all over. 3/28/2026 at 1:47 PM, Nursing Summary . On 3/12 resident did go to (Urologist) and the indwelling cath was d/c (discontinued) and the (supra pubic) foley (catheter) replaced. She did have order for Keflex (antibiotic) at that time. No reports of issues with hematuria or urine flow since changed. On 4/22/2026 at 9:42 AM, Resident #47 was observed sitting in a wheelchair by the nurses desk. Her urinary catheter bag was covered with a cloth pouch and touching the floor. On 4/22/2026 at 9:44 AM, Certified Nursing Assistant/CNA H was interviewed about Resident #47's catheter bag sitting on the floor. She walked over to the resident and looked underneath the wheelchair and said the wheelchair was short and it was hard to keep the catheter bag off the floor. Resident #47 asked Is it dragging? and CNA H stated, Yes. A review of the Care Plans for Resident #47 provided the following: (Resident #47) is at risk for urinary tract infection and catheter-related trauma: has SP (supra pubic) catheter. Date initiated and created 12/10/2026 and revised 3/13/2026 with Interventions including: Position catheter bag and tubing below the level of the bladder. Check tubing for kinks each shift, date initiated 12/10/2025. There was no mention of keeping the catheter bag and tubing off the floor. The AHRQ: Agency for Healthcare Research and Quality, Catheter Care and Maintenance, AHRQ Safety Program for Long-Term Care: CAUTI (catheter associated urinary tract infection), created and reviewed March 2017, . Drainage Bag Care: . Keep drainage bag below level of bladder and off the floor at all times.NIH (National Institute for Health) National Library of Medicine: Catheter Associated Urinary Tract Infections: Current Challenges and Future Prospects, Research an Reports in Urology, 2022 [DATE]; Catheter-associated urinary tract infection (CAUTI) is the most common healthcare-associated infection and cause of secondary blood stream infections. Catheter-associated urinary tract infections (CAUTI) are urinary tract infections occurring in an individual whose urinary bladder is catheterized or has been catheterized with the past 48 hours. CAUTIs are the most common nosocomial infections, and account for 1 million cases per year in the United States.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility 1) Failed to date 5 of 7 bottles of liquor, liqueurs, and cocktail additives, used for Happy Hour for the residents, were opened, 2) Failed to label and date 2 of 2 clear containers of yogurt left in Resident #15's room and 3) Failed to ensure that Freezer and Refrigerator temperatures in the A-Wing Nourishment room were within an acceptable range for 1 of 2 Nourishment rooms . Findings Include: Kitchen: On 4/20/2026 at 9:55 AM, during a tour of the kitchen storage room with Dietary Aide B and [NAME] D a crate with opened liquor bottles, liqueurs and cocktail additives was stored on a shelf. A bottle of opened Grenadine (a red, sweet syrup used in cocktail mix) was opened and not dated when opened; a 1/2 gallon bottle of Rum was 3/4's empty and was not dated when opened; a bottle of Amaretto (a sweet liqueur) was opened and not dated when opened; Agave nectar was opened and not dated when opened; a bottle of Agave silver tequila was 1/2 empty and not dated when opened. Both the [NAME] D and Dietary Aide B said the liquor, liqueurs and additives were for the Activities department resident parties and should not have been there and needed to be dated. One bottle of Vodka had a written date on it, the rest of the items had not date. On 4/20/2026 at 10:35 AM, during a tour of the A-wing Nourishment room with Dietary Aide B, she said the Nourishment room contained food for residents and the refrigerator and freezer in the room was for resident food. When the freezer door was opened, 2 long blue ice packs were stored in the door shelves of the freezer; they appeared soiled, and one had peeling writing on it. Nurse C came into the Nourishment room and removed the ice packs. She said she wasn't sure why they were in the freezer, but they should not be there. During the tour of the A-wing Nourishment room on 4/20/2026 at 10:40 AM, a temperature log was noted hanging on the side of the refrigerator. It was dated for April 2026 and contained refrigerator and freezer temperatures for April 1st- April 20th. There was no range of acceptable temperatures identified on the document titled Refrigerator Temperature Record. The temperatures were taken and recorded by the staff twice a day- morning and evening. The refrigerator and freezer temperatures were reviewed and identified the following: Freezer: On 4/2/2026 the temperature was 2 degrees Fahrenheit and on 4/3/2026 the temperature was 4 degrees Fahrenheit; on 4/13/2026-4/18/2026 the temperature was also 4 degrees Fahrenheit. The remainder of the freezer temperatures were -4 to 0 degrees Fahrenheit. Refrigerator: The majority of the temperatures were 30-32 degrees Fahrenheit. On 4/20/2026 at 10:45 AM, Dietary Aide B was asked what the range of acceptable temperatures for the freezer was and she said it should be 0 or below. When asked about the temperatures above 0 degrees Fahrenheit, she said they were too high. The Dietary Aide B was asked about the refrigerator temperatures and said they needed to be less than or equal to 41 degrees Fahrenheit. There was a variety of residents' food and drinks in the refrigerator and with the temperatures usually at 30 degrees Fahrenheit, they could begin to freeze, as the foods in the freezer could begin to thaw. On 4/22/2026 at 9:46 AM, Infection Preventionist Nurse F was interviewed about the refrigerator and freezer temperatures in the A-wing Nourishment room. She checked the freezer thermometer inside the freezer, and it said 11 degrees Fahrenheit. She said she contacted the Maintenance department about the prior temperatures, and they were going to look at the refrigerator and freezer. She said the facility policy said the freezer was to be below 0 degrees Fahrenheit and the refrigerator 38-41 degrees Fahrenheit. Resident #15: A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #15 was admitted to the facility on [DATE] with diagnoses: Heart failure, diabetes, anxiety, depression, back pain, fibromyalgia, arthritis, epilepsy and hypothyroidism. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and needed some assistance with care. On 4/20/2026 at 12:02 PM, during a tour of the facility, Resident #15 was observed sitting in a wheelchair in her room near a bedside table. On the table were (continued on next page)

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	04/22/2026

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2 clear containers with clear lids. They each contained a thick white creamy substance, unidentifiable. Nurse E and Certified Nursing Assistant/CNA G entered the room and were asked what the substance was. They said it was yogurt from her meal tray. Resident #15 said one was from her breakfast tray and the other was from the day before. Neither container was labeled or dated to identify the item and ensure it was stored safely. The staff discarded the items with the resident's approval. CNA G said she thought the yogurt was usually labeled/dated. A review of the facility policy titled, Food Purchasing and Storage, dated origination 8/1/2011 and last approved 3/11/2026 provided, Policy: It is the policy of this facility to receive, store, and efficiently issue foods, nonfood items, and supplies. All food items will be dated with the In Date (or Delivery Date) . A review of the facility policy titled, Nourishment Room Refrigerator, origination date 8/1/2011 and last approved 3/11/2026 provided, Policy: Nourishment Room Refrigerators will be maintained under Sanitary conditions. Procedures: 1. Temperatures will be checked and recorded twice a day, morning and evening, on the temperature logs by a facility Designee. 2. Elevated or abnormal temperatures will be reported to the Maintenance department immediately.