

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/13/2025
NAME OF PROVIDER OR SUPPLIER  Maple Woods Manor		STREET ADDRESS, CITY, STATE, ZIP CODE  13137 North Clio Road Clio, MI 48420	

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 0584  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	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.  (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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intakes 2575094 and 2581072. Based on observation, interview and record review the facility failed to maintain a safe, functional, sanitary and comfortable environment, resulting in ambient temperatures of 84 degrees in resident care areas, no documentation of room or hall temperatures during an air conditioning outage, staff complaints of warm temperatures, residents discharging from the facility due to high temperatures, lack of available linen to provide peri-care and the increased likelihood of unmet care needs. Findings include: Environment: On 8/12/25 at 11:54am, an interview was conducted with Maintenance Assistant A. Maintenance Assistant A was asked when the air conditioning (AC) unit went out on the west short hall. Maintenance Assistant A stated that they believe the unit went out during the week of 07/21/25. Maintenance Assistant A was asked what caused the outage. Maintenance Assistant A stated that the contactor on unit 5 was wired incorrectly, we called an electrician for [NAME] (contractor for the heating/cooling system) to come out to look at this. There was a shunt on the contactor for unit 5, so they swapped out contactors and wired it correctly. After the repairs it was continuing to blow fuses, this was due to stress on the unit. Since then we have dismantled it and thoroughly cleaned it. There is not as much as amp draw now, the unit is running better now. Now that it is not drawing excess current we shouldn't have anymore blown fuses. What unit was affected by the outage. Maintenance Assistant A stated that the west unit short hall was the unit affected by the outage. How long was it out for. Maintenance Assistant A replied, I would say that it was just over 24hrs that they were without air conditioning. What mitigation interventions did you put in place. Maintenance Assistant A stated, we have a strong ac unit at the main hall, near the west hall area. We used very strong fans to blow the cold air down the hall and then used fans to push it into the rooms. We made sure the unit was turned off so it would not blow warm air and made sure that the wall units were in standby mode. Were there any complaints by residents that it was too hot. Maintenance Assistant A stated that some residents did complain about the heat. Maintenance Assistant A stated the air temperature in the rooms and halls was 84 degrees at the most. Did any residents asked to be moved from their room. Maintenance Assistant A stated that no residents directly asked to be moved from the unit, but some residents commented that if this doesn't get fixed they want to go home. On 8/12/25 at 12:07pm, an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated they were aware that the ac went out on the short west hall. The NHA stated that we made multiple calls to [NAME], I believe they came out on 7/24/25. What did you put in place to mitigate the heat. The NHA stated that we made sure no one had their windows open, we had fans in the hallway and rooms. Did you receive any requests from residents to be moved off the unit. The NHA replied, no. Did you receive any complaints about the warm temps. The NHA stated that the husband of a resident made a statement that it was warm and that his son had a friend that worked at [NAME], and he was going to call them himself to help the facility. The NHA was asked if they had the ability to contact other companies to fix issues. The NHA stated that they can handle these issues on their own and does not need any approval from corporate staff. The NHA stated that on 7/21/25 that short west hall ac unit went out, [NAME] came out for repairs on 7/24/25, then again on 8/8/25 when the system malfunctioned again along with another unit. The NHA stated that [NAME] was notified on 7/21/25 that there was an issue, [NAME] said they could come out on 7/24/25 at 8am to repair the unit. Do you get to use certain vendors. The NHA stated, yes, we have preferred vendors that we use. We have a contract with [NAME] for services like this. On 7/24/25 [NAME] made the necessary repairs to that ac unit and then they came back out on 8/8/25 to repair it again. I believe the unit went down before then but I can't be sure of the exact date it did. The NHA provided copies of invoices for review of the services provided by [NAME]. On 8/12/25 at 12:42pm, an interview was conducted with Unit Manager (UM) B. UM B stated they were unsure what day the unit went out, but said we put a large fan at the corner trying to blow the air down the hall to keep residents cool. UM B was asked how long the unit was without ac. UM B stated, I believe the ac was out for over a week and half, [NAME] came out and looked at other units but didn't fix this one. We grabbed fans for residents who asked for them specifically, resident families brought in fans, we increased fluids. UM B was asked if they ever asked about the temperatures in the hall and rooms. UM B stated they asked about temperatures in the rooms, and every time they did ask, they were informed that the temperatures fell within the correct range. UM B stated they were never given an exact temperature of any of the rooms or the hall. Did other residents complain about the heat. One resident, resident C, left 24hrs after arriving due to the</p>		