STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235518	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Woods Manor	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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 3026069. Based on observation, interview and record review, the facility failed to ensure access to and answer call lights timely for three residents (#31, #49, #106) and a Confidential Group of Residents, resulting in the lack of timely care, residents' verbalizations of dissatisfaction with care and unmet care needs. Findings include: Resident #31: On 6/1/26 at 12:05 PM, Resident #31 was observed sitting in a recliner in their room. An untouched food tray was in place on the overbed table in front of them. An interview was completed at this time. When queried why they were not eating their food, Resident #31 adamantly responded they did not like what they received and that it was inedible. When asked if they were able to request something different to eat, Resident #31 responded they could but indicated it would be quite a while before someone answered their call light. Resident #31 pressed their call light at 12:08 PM. At 12:10 PM, two staff members were observed talking in the hallway in close proximity to Resident #31's room. Resident #31 also saw the staff. Upon saying it should not be long before one of the staff answer their call light, Resident #31 chuckled and said, It (call light) might be on but that doesn't mean they are looking at it. The light in the hallway directly above Resident #31's door, signifying the Resident's call light was on, was checked to verify it was working. The staff were still talking in the hallway. After talking for a couple more minutes, the staff members walked away without answering the Resident #31's call light. When queried if they needed assistance from staff to use the restroom, Resident #31 replied, Yeah. Resident #31 was then asked if staff assist them when they need help and replied, Depends on who is working. Resident #31 did not provide further details when asked. At 12:34 PM, a Certified Nursing Assistant (CNA) walked past Resident #31's room without acknowledging and/or answering the call light. Resident #31's call light remained on and unanswered at 12:34 PM. An interview was completed with Infection Control Licensed Practical Nurse (LPN) C on 6/1/26 at 12:35 PM. When queried what an acceptable time frame is for a Resident to wait for their call light to be answered, LPN C would not provide a specific time frame and stated, Should be answered as soon as possible. When queried if almost 30 minutes was acceptable, LPN C stated, That is not okay. I will go check. No further explanation was provided. Record review revealed Resident #31 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinsons disease, left hand contracture, and diabetes mellitus. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required set up to total assistance to complete Activities of Daily Living (ADLs). (continued on next page)

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	On 6/2/26 at 4:23 PM, an interview was completed with the Director of Nursing (DON) and Clinical RN N. When queried what an acceptable length of time to wait for a call light to be answered by a facility staff member, RN N responded that it varied from resident to resident and was what the individual resident felt was acceptable. The DON and RN N was informed of observation of Resident #31's call light being on for almost 30 minutes as well as staff standing in the hall talking and a CNA walking past without answering the light. When queried if that was acceptable, RN N verbalized it was not. Resident #49: In an interview on 06/01/2026 at 10:03 AM with Resident #49 revealed that the staff come in and shut the light off, and say they will come right back, but they don't come back. The weekends are the worst; the lights are a long time to get answered. They told Resident 49 that the light did not work outside the room. Resident demonstrated call light did work outside the room. Third shift are lazy, and don't check on us, there are a few bad apples. In an interview on 06/01/2026 at 1:51 PM, the Activities Director D brought the Resident Council meeting notes for review. The State surveyor requested concern forms from the meetings to review. In an interview and record review on 06/01/2026 at 2:48 PM with the Nursing Home Administrator (NHA) Record review of resident council meeting notes concerns was recorded on the Resident & Family Concern Reports. The surveyor requested reports to review. NHA to get resident & Family concern forms to be reviewed. Resident council meeting to be held at 1:00PM on 6/2/2026 in the East dining room. In an interview on 06/01/2026 at 3:37 PM Resident #49 Revealed: The call lights are taking longer, from half hour to an hour response time. The staff are shutting off the call light and staff don't come back- it does take the staff a long time to get what the residents want, again a half hour to an hour. At weekends the call lights are longer than 1 hour. Getting to the bathroom is slow and takes too long, the resident stated that they take a water pill and staff just tell them to wait. Record review on 06/02/2026 at 10:18 AM of Resident & Family concern forms for the last 6 months revealed that there were multiple concerns with call lights taking 30 minutes to an hour to get staff to respond. In interviews on 06/02/2026 at 1:00 PM in the East dining room confidential resident meeting with state surveyor inquired if Call light response was timely- 6 of 10 Residents acknowledged that they have waited an hour or longer to get call light assistance, and 4 of 10 stated that they had waited 20 to 30 minutes to use the restroom or get assistance. 9 of 10 residents (One did not respond) acknowledged short staffing usually over the weekends there are call-ins and no shows, the weekends are the worst for short staffing. That's when the call lights get longer waits for help. Resident #106 (R106): On 06/01/2026 at 3:46PM, R106 was asked if the facility answers call lights in a timely manner. R106 stated, no and that third shift is the worst, they will see my call light on and just stand outside of my (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	room. I will yell out to them that I need help, and they will just keep walking by. I have this bell I can ring as well, when I see them standing outside my door I will ring it over and over until they finally come in. R106 was asked how long it takes to get her call light answered. R106 stated that it depends on the shift and who is working, but that most times it is at least 30 minutes and sometime up to an hour.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure palatable and appealing food for three residents (R6, R41 and R106) of five residents reviewed for food and a confidential group of residents. Findings include: Resident #106 (R106): R106 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease (COPD), chronic respiratory failure and cerebral infarction without residual deficits. On 06/01/2026 at 3:52PM, R106 was asked about the food the facility serves. R106 stated, the food is cold and she gets tired of getting cold food in her room. R106 says she has to have kitchen staff warm up items for her constantly. R106 stated that this occurs at all meals. On 06/02/2026 at 1:18PM, an interview was conducted with Dietary Manager (DM) L. DM L was asked if they have ever received complaints of cold food. DM L stated, I have and especially when I first started at the building. DM L stated the complaint is that by the time the food gets to residents in their rooms it is cold. We are losing temperature from the service area to the room. When I do get complaints, I do try to tackle them and see if there is a way we can change things or improve them. DM L was asked if the facility has insulated domes for the plates. DM L stated, yes and we have plate warmers as well. DM L stated that most of the cold food complaints comes from the west end and half of the central unit (serviced by west dining room). Resident #6: An interview on 06/01/2026 at 10:33 AM with Resident #6 revealed Cold foods if you eat in the rooms and that the Food is not that good. In an interview on 06/02/2026 at 8:03 AM, Resident #6 was up in her wheelchair stated that she was going to be leaving today for assisted living. When asked about the food at the facility she stated that it was not very good and most of the time the food was cold. The surveyor asked for examples of cold food items, and she stated that the eggs are cold in the mornings and the lunch if you eat in the dining room will be warm, but if she ate in the resident room the food was cold. When asked about the variety of choices the resident stated that it could be better, the other (alternative) choice menu was tiresome. Resident #49: In an interview on 06/01/2026 at 8:57 AM, Resident #49 stated that the food is cold and mushy, She does not like the food and the alternate menu takes too long to get if you request it during mealtime. Dining Observation: Observation on 06/02/2026 at 7:25 AM of the [NAME] dining room, noted 8-10 residents being served breakfast of Cinnamon French toast, oatmeal, sausage. Cook/server H and Dietary Aide I were plating the food items to trays. Observation of the tray line noted that the bottom insulated plate holder is (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	coming off a large stack of dark blue bottoms from a shelf across from the steam table and the plates are in a stack from the plate rack with an open top and an insulated domed top is placed over the plate. The trays are placed on a rolling cart and then sent over to the beverage station for the Certified Nursing Assistance to fill the glasses and cups prior to leaving the dining room for hall trays. The rolling cart is then pushed out to the nursing units and then distributed to the resident rooms. In an observation on 06/02/2026 at 7:51 AM of the East dining room meal tray prep, the state surveyor followed a meal tray process from the meal is plated in the kitchen and placed on rolling cart. Certified Nursing Assistant (CNA) K prepped the rolling cart with beverages and then took the cart with 4 meal trays to the nursing care unit to room [ROOM NUMBER]. Random Resident #54 was presented with breakfast meal tray in her room. The state surveyor asked for permission from the resident to touch the bottom edge of the white ceramic plate and the plate was cold to the touch. There was no heat felt in the plate by surveyor. Resident #54 stated that the food is always cold. She does eat in her room most of the time. She has a cold plate, and they pour cold syrup over the French toast, and it just could be better. In an interview on 06/02/2026 at 8:00 AM, Certified Dietary Manager (CDM) L revealed that the [NAME] M plates were taken from a stack, on the counter. The cook grabbed stack of ceramic plates of 6, placed on countertop and plated food items to the plates. The CMD stated that the plates should remain in the plate warmer until ready to be used. Interviews on 06/02/2026 at 1:00 PM in the East dining room, revealed 9 of 10 residents stated that the food is cold, the plates are cold and it doesn't matter if they are in the dining room or eat in the resident room. Complaints of too much pasta, too many chicken and pork dishes, and the mashed potatoes have dry clumps from instant potatoes mix, need to be mixed more. Observation on 06/03/2026 at 7:46 AM observation of the west breakfast dining room, service is from the steam table, plate warmer was plugged in and the light was on yellow, observed cook to stack 5 plates with thermal bottoms into a stack right on top of each plate and set them on the edge of the steam table. The cook/server took time to read the meal tickets for residents prior to plating any food. An interview on 06/03/2026 at 9:09 AM with the Certified Dietary Manager (CDM) L revealed that the process it to cook everything in the kitchen and portion into steam tables pans, keep in hot oven, then 20 minutes closer to serve time the pans are place in a Cambro insulated box to take to the west dining room, and temp food items. At 7:00AM we start, we serve in dining room first, and then at 7:30 we start to shuttle out the meal trays on the tiered carts, and the CNAs put the drinks on the trays and take them to the hallway. We don't have thermal heated bottoms we just have the insulated bottoms. Yesterday the East breakfast plates were cool, the plate warmer was not on when you were watching the cook, she is our new cook and she is struggling a little, and the plates were cold. I did turn it on for her when I realized. The surveyor explained observation of the west dining room breakfast cook was Stacking the thermal bottom with a ceramic plate and would place another thermal bottom and a ceramic plate on top until she had a stack of 5 on top of each other. The CDM L stated no that should not be done, as the plates get cold. The plate should not be removed from the plate-warmer until the cook is ready to plate the food.