

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Autumnwood of Deckerville was surveyed for a Recertification Survey exiting on 03/06/2025. Event ID:LJAE11 No Intake Numbers Census: 75	F0000		
F0552 SS= D	Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to notify three residents' (#42, #68 & #75) responsible parties of initiation and changes to their medication regime of five residents reviewed for unnecessary medications.	F0552	1. Res. #42's responsible party was notified and agreed to use of anti-depressant and anti-anxiety medications. Update was given to responsible party on all changes and adjustments that have been made. Res. #68's responsible party was contacted and consent was obtained for use of anti-psychotic medication. Responsible party was also updated on all recent changes or adjustments and behaviors. Res #75's responsible party was notified and agreed to use of anti-anxiety medication. Update was given to responsible party on all changes and adjustments that have been made. 2. Social Service Designee reviewed other residents in the building receiving psychotropic medications to ensure appropriate notification and consents were received. 3. Notification of Change Policy and Procedure was reviewed by the IDT team. All Nurses, RD and Social Service Designee were in-serviced on the Notification of Change Policy. 4. Director of Nursing or designee will audit 25% of all psychotropic medication new orders in stand up meeting weekly x4, then monthly x 2 to ensure that notification and consent was obtained. Any concerns will be	4/3/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/26/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Findings Include:</p> <p>Resident #42:</p> <p>On 3/5/2025 at 9:00 AM, a review was conducted of Resident #42's clinical records and it indicated the resident admitted to the facility on 8/2/2024 with diagnoses that included, Dementia, Adjustment Disorder, Delusional Disorder, Depression, Anxiety and Schizophrenia. Resident #42 was deemed incapable of making decision for herself and a guardian was appointed. Further review was completed of Resident #42's Cymbalta (antidepressant medication) and Buspirone (antianxiety medication) orders and changes since admission which yielded the following:</p> <p>Physician Orders:</p> <p>Buspirone:</p> <p>Started on 2/12/2025. Give 5 mg (milligrams) by mouth two times a day for anxiety.</p> <p>Cymbalta:</p> <p>Started on 10/2/2025. Give one-20 mg capsule by mouth one time a day for depression.</p> <p>Started on 12/18/2025: Give one- 40 mg capsule by mouth one time a day for depression.</p>		<p>addressed. Results of audit will be reported to QA Monthly. Director of Nursing will be in charge of sustained compliance.</p> <p>Director of Nursing or designee will audit 25% of the resident currently on psychotropic medications to ensure the responsible party was contacted and consented to anti-psychotics and agreed to anti-anxiety and anti-depressant medication. Responsible party was also updated on all recent changes or adjustments and behaviors weekly x4, then monthly x2 to ensure that notification and consent was obtained. Any concerns will be addressed. Results of audit will be reported to QA Monthly. Director of Nursing will be in charge of sustained compliance</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Started on 1/15/2025. Give one-60 MG capsule by mouth one time a day for depression.</p> <p>Progress Notes:</p> <p>9/30/2024 at 16:02: (Psychiatric Nurse Practitioner Note): "...Will decrease Prozac and use Cymbalta 20 mg qd for mood and pain relief ...".</p> <p>10/2/2024 at 13:23: "First dose of Cymbalta 20 MG given this am ..."</p> <p>12/16/2024 at 16:40: (Psychiatric Nurse Practitioner Note): "...increase Cymbalta to 40 MG daily ..."</p> <p>1/13/2025 at 15:35 (Psychiatric Nurse Practitioner Note): "...Will increase Cymbalta to 60 mg daily to help with crying and yelling episodes ...".</p> <p>1/15/2025 at 11:14: "...Medication change increase Cymbalta to 60 mg daily dx (diagnosis) depression</p> <p>2/12/2025 at 14:38: "Buspar 5 mg was initiated this am. There have been no adverse effects noted so far ..."</p> <p>2/14/2025 at 10:39: "Cymbalta increase and Buspar initiated ...tolerating increase in Cymbalta and initiation of Buspar with no noted adverse effects ..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>2/20/2025 at 11:22: "(Resident #42) is tolerating increase in Cymbalta and initiation of Buspar with no noted adverse effects.</p> <p>There was no documentation located from facility staff that indicated the guardian consented to the usage of antianxiety and antidepressant medications and their subsequent dosage increases.</p> <p>Resident #68:</p> <p>On 3/4/2025, at approximately 12:30 PM, Resident #68 was observed walking about the hallways of the unit. He was pleasantly confused and unable to hold a conversation due to his disease process. The nurse reported his behaviors are unpredictable at times, but the staff do well with anticipation of his needs and different interventions.</p> <p>On 3/5/2025 at 10:00 AM, a review was conducted of Resident #68's clinical record and it revealed he admitted to the facility on 8/9/2024 with diagnoses that included, Dementia, Adjustment Disorder, Anxiety, Depression and Psychotic Disorder. Resident #68 does not have the capacity to make his own decisions and had a guardian appointed. Further review was conducted of the records and yielded the following:</p> <p>Physician Orders:</p> <p>Haldol (antipsychotic medication) Injection Solution 5 MG (milligrams)/ML (milliliters)-</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>inject 2.5 mg intramuscularly (IM) every 2 hours as needed for severe agitation for 14 days. Ordered on 2/21/25.</p> <p>Progress Notes:</p> <p>2/21/2025 at 04:09: "Resident extremely behavioral towards staff and very aggressive. He began hitting staff, cussing, and disrupting other residents. He was inconsolable and nothing could calm resident down. He would not take any PO meds despite attempt. (contracted psychiatric group) contacted, could not reach. (Nurse Practitioner) contacted and emergency order obtained for haldol 2.5mg IM. administered and awaiting effectiveness. Resident then began chasing staff."</p> <p>2/21/2025 at 04:08 - Medication Administration Note: "Haldol Injection Solution 5 MG/ML. Inject 2.5 mg intramuscularly every 2 hours as needed for severe agitation."</p> <p>2/27/2025 at 13:53: "Reviewed Clinical Indicator...In addition, PCP added Haldol 2.5 mg IM q (every) 2 hours PRN through 3/7/25 for aggression on 2/21/25. He has only required one dose 2/21/25. Seroquel titrated down and discontinued 2/25/25 ...".</p> <p>There was no documentation located from facility staff that indicated the guardian consented to the usage of the antipsychotic medication or was informed of the events</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>that led to Resident #68 being administered the medication.</p> <p>Resident #75</p> <p>On 3/5/2025 at 9:30 AM, a review was conducted of Resident #75's medical records and it indicated she admitted to the facility on 12/9/2024 with diagnoses that included, Vascular Dementia, Alzheimer's, Adjustment Disorder, Psychotic Disorder and Depression. Resident #75 was deemed incapable of making decisions and with her daughter as her responsible party. Further review was completed of Resident #75's Lorazepam (antianxiety medication) and Klonopin (antianxiety medication) orders and changes since admission which yielded the following:</p> <p>Physician Orders:</p> <p>Klonopin:</p> <p>Started on 1/22/2025. Given one 0.5 mg tablet by mouth two times a day for anxiety.</p> <p>Started on 2/9/2025. Given one 0.5 mg tablet by mouth three times a day for anxiety.</p> <p>Lorazepam:</p> <p>Started on 2/18/2025: Give one tablet by mouth every 12 hours as needed for Anxiety and restlessness for 14 days.</p> <p>Progress Notes:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>1/22/2025 at 09:57: "Recent medication changes of starting Klonopin 0.5mg BID. Received first dose this morning ...".</p> <p>1/21/2025 at 21:20: "Resident to being klonopin 2x/da beginning tomorrow for anxiety."</p> <p>2/20/2025 at 11:27: " ...Nursing obtained PRN (as needed) Ativan order from PCP (primary care) x 14 days ...".</p> <p>2/18/2025 at 13:25: " ...Klonopin as ordered helpful with Ativan 0.5 mg q(every) 4 hour as needed ...".</p> <p>2/17/2025 at 16:00: (Psychiatric Nurse Practitioner)" ...Klonopin 0.5 mg tid for anxiety, pacing, fretful, restless, anxious wandering ...".</p> <p>2/14/2025 at 10:45: " ...In addition on call NP (nurse practitioner) increased Klonopin from 0.5 mg BID (twice a day) to 0.5 TID (three times a day) r/t (related to) increased anxiety ...".</p> <p>There was no documentation located from facility staff that indicated the guardian consented to the usage of antianxiety medications and their subsequent dosage changes.</p> <p>On 3/5/2025 at 11:00 AM, Social Services Director "A" was asked about Resident #68's Haldol administration and if his guardian was</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>alerted and consented to the medication. Director "A" explained in this situation the nurse could have contacted the guardian after the fact, but he would follow up regarding this situation.</p> <p>Director "A" was also queried regarding Resident #75 and Resident #42's medication adjustment without notification to the responsible party. He stated he would look into each resident and follow up.</p> <p>On 3/6/2025 at 10:55 AM, Social Services Director "A" stated going forward he will take credit for his work as he knows he spoke to all the responsible parties regarding the medication's changes, but it is not documented. He continued he will document them in the "Resident at Risk" note if they are agreeable or decline the change. A discussion was held that overall it's a process change as one person cannot be wholly responsible to obtain consents or declinations for every medications change.</p> <p>Review was completed of the policy entitled, "Notification of Change," revised 2/14/2024. The policy stated, " ...The facility must inform the resident, consult with the resident practitioner, and notify, consistent with his or her authority, the resident representative (s) when there is a change in status ... A need to alert treatment significantly" means a need to stop a form of treatment because of adverse consequences, or commence a new form of treatment to deal with a problem ...the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0644 SS= D	<p>licensed nurse will document in the resident electronic medical record the notification and information that was provided ..."</p> <p>Coordination of PASARR and Assessments §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e) (1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to initiate a change in condition/PASSAR follow up for one resident (Resident #3) of five residents reviewed for PASSAR's.</p> <p>Findings include:</p> <p>Resident #3:</p> <p>On 3/04/25, at 11:51 AM, a record review of Resident #3's electronic medical record</p>	F0644	<p>1. Res. #3 had a change in condition triggered at survey by the Social Services Designee, and CMH has begun the Level 2 screening.</p> <p>2. Social Service Designee reviewed all residents in building to ensure that no other residents had missed change in condition.</p> <p>3. Social Service Designee and Admission Director were in-serviced on Pre-Admission Screening and Guest/Resident Review Policy and Procedure.</p> <p>4. Social Service Designee will audit 25% of resident population weekly x4, then monthly x2 to ensure that all PASSAR's are current and up to date. Any concerns will be addressed. Results of audit will be reported to QA Monthly. Social Service Designee will be in charge of sustained compliance.</p>	4/3/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>revealed an admission on 1/8/2025 with diagnoses that included Diabetes, Stroke and Mental illness. Resident #3 had impaired cognition and required extensive assistance with Activities of Daily Living.</p> <p>A review of the "PREADMISSION SCREENING (PAS)/ANNUAL RESIDENT REVIEW (ARR) Date 01/03/2025" revealed the "Hospital Exemption Discharge" was check marked. The boxes for "Mental Illness" were check marked.</p> <p>A review of the "OBRA PASARR CORRESPONDENCE January 21,2025" revealed "Based on review of the available information, the recipient was admitted to the nursing facility with a hospital exemption. Although the resident remains at the nursing facility, there is a tentative discharge date scheduled within 2 weeks. Therefore, a level II OBRA assessment will not be initiated at this time. If that plan changes, please notify the local OBRA Office as soon as possible for appropriate follow up. Please retrigger if individual remains past 30 days ... "</p> <p>On 3/05/25, at 1:30 PM, Social Worker (SW) Designee "A" was asked to provide any additional documentation the facility had regarding Resident #3's PASSAR correspondence.</p> <p>On 3/05/25, at 3:05 PM, a record review along with The Director of Nursing (DON) was conducted of Resident #3's PASSAR</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0676 SS= D	<p>documentation in the electronic medical record. No additional documentation was located and the DON offered they would discuss with SW "A" and would follow up.</p> <p>On 3/06/2025, at 11:00 AM, an additional record review of Resident #3's electronic medical record/Miscellaneous tab revealed a new PASSAR correspondence "Date 03/05/2025". The document revealed the "Change in Condition" was check marked.</p> <p>On 3/06/2025, at 11:30 AM, SW "A" was asked to explain the delay for the PASSAR/change in condition and SW "A" offered, they failed to complete it timely.</p> <p>A review of the facility provided "Pre-Admission Screening and Guest/Resident Review-PASRR Michigan Policy Last Revised 11/12/2021" revealed "The PASSR process was established in 1987, as part of the OBRA ruling ... If a person is admitted for a 30 day hospital exemption stay and later intends to remain in the nursing facility longer than 30 days, a Change in Condition is submitted to the local community mental health program for review. (Level 2) ... "</p> <p>Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's</p>	F0676	<p>1. Resident #76 was evaluated and picked up by Physical and Occupational Therapy.</p> <p>2. All resident□s discharged from PT or OT in the last 30 days were reviewed to ensure residents were started on a Restorative Therapy Program if ordered.</p> <p>3. Therapy Director, Nursing Staff and IDT team was educated on the Restorative Policy</p>	4/3/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to initiate a restorative therapy program to provide services to maintain or improve range of motion and mobility for one resident (Resident #76) of one resident reviewed for therapy and restorative services.</p> <p>Findings include:</p> <p>Resident #76:</p> <p>A review of Resident #76's medical record, revealed an admission into the facility on 1/23/25 with diagnoses that included adjustment disorder, heart failure, muscle</p>		<p>and Procedure as well as the ADL Policy and Procedure.</p> <p>4. Director of Nursing will audit all discharges from PT and/or OT weekly x4, then monthly x2 to ensure restorative to therapy programs were initiated as ordered. Any concerns will be addressed. Results of audit will be reported to QA Monthly. Director of Nursing will be in charge of sustained compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>weakness, difficulty in walking, and acquired absence of right toe(s). A review of the Minimum Data Set assessment revealed the Resident had a Brief Interview of Mental Status score of 8/15 that indicated moderately impaired cognition, and the Resident needed partial/moderate assistance with toileting hygiene, bathing, dressing, sit to stand mobility and needed supervision or touching assistance with bed to chair transfer, toilet transfer and walk 10 feet.</p> <p>On 3/4/25 at 11:42 AM, an interview was conducted with Resident #76 and Confidential Person "J" in Resident #76' room. The Resident was dressed and sitting on the side of the bed. The Resident answered some questions, and the Confidential Person assisted with answering and engaged in conversation. When asked about any concerns regarding the Resident's care, the Confidential Person reported that the Resident was supposed to have therapy to get her stronger and now nothing. The Resident expressed that she did not know why it stopped. The Resident reported she did not know when it stopped but indicated a week or two. The Resident reported not doing much, did not want to do the activities and stayed in bed most of the day. The Resident reported she wanted to keep doing therapy and denied refusing to go to therapy. The Resident was asked if they had started a Restorative Therapy program, and she responded she didn't know what that was. An observation was made of the Resident's</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>walker in the room. When asked if the Resident used the walker, the Resident reported she had been walking with Physical Therapy but does not remember walking since she stopped therapy.</p> <p>On 3/5/25 at 2:28 PM, an interview was conducted with Therapy Manager, (TM) "I" regarding Resident #76's therapy. Resident #76's therapy records was reviewed by the TM. The TM indicated that the Resident had stopped Physical Therapy (PT) and Occupational Therapy (OT) on 2/21/25 and that the Resident was here to stay as a long-term resident. When asked about the Resident's ability to walk, the TM reported that the Resident liked to stay in the bed a lot and needed a lot of encouragement, was walking as tolerated with pain 100 to 50 feet with stand by assistance to contact guard assistance. When asked if the Resident was a candidate for Restorative Therapy program, the TM stated, "I thought we put her on the Restorative Therapy, but I looked and could not find it in (medical record)." The TM reported that when a resident was referred to the restorative therapy, the Therapy department would put the plan in the evaluation tab for therapy to restorative and the Restorative Therapy/Unit Manager, Nurse "H" would review it after the Therapy department writes up the plan. The TM reported that the intention was to put Resident #76 into the Restorative Therapy program and stated, "It could have been a miss communication, it was not put into PCC</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(computer program for medical records). The TM reported they had gotten a referral today regarding weakness and back pain which she had when Therapy worked with her, her knees had really bad arthritis, and she had a decline in transfer. The TM reported they will look into picking her back up on therapy but if they could not pick her up, she would be a candidate for the Restorative Therapy.</p> <p>On 3/5/25 at 2:47 PM, an interview was conducted with Unit Manager/Restorative Therapy Nurse (UM) "H" regarding Resident #76's lack of transfer from Therapy to the Restorative Therapy program. The UM reported she did the Restorative Therapy for the whole building. The UM reviewed the Resident's medical record and reported the Therapy department had not sent an evaluation in the computer. When asked if the Resident was a candidate for the Restorative Therapy, the UM indicated she was and stated, "The only time she came out of her room was to go to therapy." The UM reported that the Therapy department will send a referral, she will review the recommendations and put them in as a task for the Restorative CNA's (certified nursing assistants) and the CNA's will document in the task for each recommended therapy to be continued like range of motion and walking. The UM reported she had not gotten an evaluation Therapy to Restorative Program Plan.</p> <p>On 3/5/25 at 3:29 PM, an interview was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 764012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 3/6/2025
NAME OF PROVIDER OR SUPPLIER AUTUMNWOOD OF DECKERVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 3387 ELLA ST DECKERVILLE, MI 48427		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>conducted with the Director of Nursing (DON) regarding Resident #76's lack of the development of a Restorative Therapy plan. It was reviewed with the DON of the lack of communication for the start of Restorative Therapy and identifying Resident#76's needs for a restorative therapy plan.</p> <p>A review of the facility policy titled, "Restorative Nursing," revealed, "Purpose: The facility strives to enable the resident to attain and maintain the highest practicable level of physical, mental, and psychosocial well-being. The interdisciplinary team (IDT) works with the resident and family to identify measurable restorative goals and practical interventions that can be implemented and achieved with nursing support. A licensed nurse will help manage the restorative nursing process with assistance of nursing assistants trained in restorative care ... Components of the restorative nursing program include, but are not limited to, the following: Interdisciplinary process to identify residents who would benefit from a Restorative Nursing program: referral from skilled therapy services via the Therapy to Restorative Program Plan; At care planning and other guest-focused meeting, e.g. behavior management, resident/nutrition at risk, etc.; During weekly Interdisciplinary Team Meeting (ITM)/Utilization Review Meeting; Morning clinical meeting ..."</p>				