| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235471 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/22/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Life Care Center of Plainwell | 320 Brigham St<br>Plainwell, MI 49080 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027<br><br>This citation pertains to intake #'s MI00145569 & MI00146066<br><br>Based on interviews and record review, the facility failed to protect the residents' right to be free from mental and verbal abuse by staff for 3 residents (Resident #102, 103, & 105) of 6 residents reviewed for abuse/neglect, resulting in verbal intimidation, and the potential for psychosocial harm.<br><br>Findings include:<br><br>This surveyor requested Concern and Grievance reports from the Nursing Home Administrator (NHA A) on 8/21/24, for Resident #102, #103, and #105.<br><br>Resident #102<br><br>Review of an Admission Record revealed Resident #102 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke.<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 7/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #102 was cognitively intact.<br><br>Review of Resident #102's Care Plan revealed no information related to the residents level of assistance with toileting, skin integrity intervetions, and/or risk for pressure ulcers.<br><br>Review of Resident #102's a Witness Interview/Statement Form, dated 8/4/24 revealed, .Incident date/time: 8/3/24 NOC (night time) .person conducting interview: (Registered Nurse (RN) D). The following is a statement of the facts as reported by the above-named witness: Aide told me to not pee the bed while putting me on the bedpan. At the bottom of the form it was noted, (Certified Nursing Assistant (CNA) G) Terminated. This document was identified as a Concern/Grievance report, per NHA on 8/21/24.<br><br>(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 |
|---|---|---|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235471 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/22/2024 |
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| NAME OF PROVIDER OR SUPPLIER: Life Care Center of Plainwell | | STREET ADDRESS, CITY, STATE, ZIP CODE: 320 Brigham St Plainwell, MI 49080 | |

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|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 8/21/24 at 11:47 AM, RN D reported that she had written the report about Resident #102 because the resident's daughter was in the room, and reported that Resident #102 had been left on the bedpan all night, and then the resident had spoke up and stated that CNA G had told her that she better not pee in bed again, and then put the bedpan under her. RN G reported that MASD (moisture associated skin disorder) had been identified on the resident's buttocks prior to that day, and when she physically assessed the resident, the MASD was still present, but she was unsure if the condition had worsened as a result of being left on the bedpan for an extended period of time. RN D reported that the next day 8/4/24, another resident had reported a concern with CNA G, and that was the first time she realized that there may be a problem. RN D then reported Resident #102's concern to Unit Care Coordinator (UCC) F, and wrote the interview/witness statement noted in the previous paragraph.<br><br>This surveyor attempted to interview UCC F via phone on 8/21/24 and 8/22/24, with no return call.<br><br>In an interview on 8/20/24 at 8:50 AM, Family Member (FM) L reported that Resident #102 told her that CNA G had been rough with her, yelled at her about wetting in the bed, and left a bed pan under her all night. FM L reported that Resident #102 was not mobile in or out of bed due to a recent stroke, and was incontinent.<br><br>Resident #103<br><br>Review of an Admission Record revealed Resident #103 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke.<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 7/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #103 was cognitively impaired.<br><br>Review of Resident #103's Care Plan revealed, .Focus: Bowel incontinence. Date initiated 7/12/24, Interventions: .Assist with bowel elimination needs as needed. Date initiated: 7/12/24, Check resident every two hours and assist with toileting as needed. Date initiated: 8/20/24 .Focus: Urinary Incontinence: .chooses to not use a urinal for bladder elimination. Date initiated: 7/12/24, Revision on : 8/20/24. Interventions: Assist with incontinence care as needed .is able to notify staff when he has had an incontinent episode. Date initiated: 8/20/24.<br><br>In an interview on 8/20/24 at 9:57 AM, Resident #103 reported that there are CNA's on the night shift that are rude and give him a hard time. Resident #103 reported about a specific concern; a couple weeks ago he was having frequent bowel movements during the night and had to press his call light multiple times to have his brief changed, the CNA told him that if he messed his pants again that he would just have to wait for the next shift, because she wasn't going to change him again. Resident #103 reported that he and Family Member (FM) O filled out a complaint form about the CNA with facility, and had not seen the CNA since. Resident #103 reported that CNA K was also very stern with him, it was her way or the highway, and CNA K told him that it was against the rules to not wear the facility gowns to bed. Resident #103 reported that he gets warm during the night and had to cut the strings on the gown to get it off, because CNA K tied it so tight.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Life Care Center of Plainwell | | STREET ADDRESS, CITY, STATE, ZIP CODE 320 Brigham St Plainwell, MI 49080 | |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #103's Concern & Comment Form completed by Resident #103 and Director of Rehabilitation (DOR) J dated 8/2/24 at 10:32 AM revealed, Last week an aide from 3rd shift told him If you go again you are just going to have to wait for 1st shift. At the bottom of the form it was noted, CNA G Terminated. The form was submitted to this surveyor with the investigation and response portion incomplete, and then resubmitted with the following information added. Associate receiving concern/comment: (DON B) date: 8/5/24 at 10:00 AM .Investigation findings: employee was found to not provide customer service to (nursing home name) standards .immediate removal from concerned party assignment, employee terminated .<br><br>In an interview on 8/20/24 at 4:07 PM, DOR J reported that Resident #103 and FM O reported the concern regarding a night shift CNA to her, during a therapy session. DOR J did not discuss the concern with anyone, she simply completed the concern form and gave it to the DON.<br><br>In an interview on 8/20/24 at 4:00 PM, DON B reported that she had found Resident #103's concern form in her mailbox on 8/5/24 (3 days after it was completed), and did not interpret it as an allegation of abuse or neglect, and did not see a reason to report it to the State Agency. DON B reported that she completed the follow up portion of the concern form on 8/20/24. DON B reported that she would have expected the form be hand carried to NHA A and or DON B, to ensure a timely response to the resident's concern. DON B reported that CNA G was terminated following the complaint investigation, due to attendance concerns within her 90 day probation period.<br><br>Resident #105<br><br>Review of an Admission Record revealed Resident #105 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 6/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #105 was cognitively intact.<br><br>Review of Resident #105's Care Plan revealed, .Focus: Bowel incontinence. Date initiated: 6/9/24. Interventions: Assist with toileting as needed. Date initiated: 6/9/24 .Focus: Urinary incontinence. Date initiated: 6/9/24. Interventions: Assist with toileting as needed. Date initiated: 6/9/24 .<br><br>In an interview on 8/21/24 at 10:37 AM, Resident #105 reported that she dreads when the night shift starts because the CNA's are not nice. Resident #105 reported that CNA G says, What do you want? and then acts like she is annoying her when she needs her incontinence brief changed. Resident #105 reported that CNA K is intimidating and told her that she (Resident #105) was not allowed to wear pajamas to bed, and then wakes her up and takes them off of her.<br><br>Review of Resident #105's Witness Interview/Statement Form, dated 8/3/24, completed by CNA AA revealed, Incident date/Time 8/3/24 (no time) .Aide told me to not pee anymore so she didn't have to change me.<br><br>In an interview on 8/21/24 at 9:42 AM, CNA G reported that on 8/4/24 she was informed on 8/4/24 by UCC F that she would need to work on the other unit, due to a resident complaint. CNA G reported that she worked for about 5 hours that night and then had to leave due to a family emergency. CNA G reported that she received a phone call the next day, and was terminated from the facility due to multiple resident complaints. CNA G reported that there were several residents that are heavy wetters and are on their call lights a lot during the night.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER: Life Care Center of Plainwell | | STREET ADDRESS, CITY, STATE, ZIP CODE: 320 Brigham St Plainwell, MI 49080 | |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 8/21/24 at 3:00 PM, Licensed Practical Nurse (LPN) C reported that she was the manager on call the weekend of 8/2/24-8/4/24, and RN D called her on 8/4/24 to discuss care concerns reported by three residents regarding CNA G. LPN C reported that she had interviewed the staff that had taken the concerns from the residents, and then advised RN D to contact the abuse coordinator, NHA A regarding the concerns. LPN C reported that UCC F was also instructed to pull CNA G aside when she reported for work on 8/4/24, to educate her on customer service expectations. LPN C reported that she did not have the ability to submit a FRI (facility reported incident) to the State Agency, because she did not have a login.<br><br>In an interview on 8/21/24 at 4:14 PM, Social Services Director (SSD) I reported that she had not been made aware of Resident #102, #103 and/or #105's reported concerns related to CNA G, and therfore had not followed up with these residents.<br><br>In an interview on 8/21/24 at 8:00 AM, Nursing Home Administrator (NHA) A reported that CNA G was terminated on 8/5/24, due to not meeting customer service expectations for three residents that had expressed concerns, (Resident #102, #103, and #105). NHA A reported that following the reported concerns, she did not interview other residents, she did not interview staff that worked with CNA G, she did not know if anyone followed up with the residents, and she did not report the residents' concerns to the State Agency. NHA A reported there was no additional information to provide regarding the resident concerns. |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027<br><br>This citation pertains to intake #'s MI00145569 & MI00146066.<br><br>Based on interview and record review, the facility failed to report allegations of abuse to the State Agency in a timely manner for 3 residents (Resident #102, #103, & #105) reviewed for abuse and neglect, resulting in the potential for continued violations involving mistreatment, neglect, or abuse going undetected, unreported, or without thorough investigation.<br><br>Findings include:<br><br>Resident #102<br><br>Review of an Admission Record revealed Resident #102 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 7/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #102 was cognitively intact.<br><br>Review of Resident #102's a Witness Interview/Statement Form, dated 8/4/24 revealed, .Incident date/time: 8/3/24 NOC (night time) .person conducting interview: (Registered Nurse (RN) D). The following is a statement of the facts as reported by the above-named witness: Aide told me to not pee the bed while putting me on the bedpan. At the bottom of the form it was noted, (Certified Nursing Assistant (CNA) G) Terminated. This document was identified as a Concern/Grievance report, per Nursing Home Administrator (NHA) on 8/21/24.<br><br>In an interview on 8/21/24 at 11:47 AM, RN D reported that she had written the report about Resident #102 because the resident's daughter was in the room, and reported that Resident #102 had been left on the bedpan all night, and then the resident spoke up and stated that Certified Nursing Assistant (CNA) G had told her that she better not pee in bed and then put the bedpan under her. RN D reported that the next day 8/4/24, another resident had reported a concern with CNA G, and that's when she realized that there may be a problem. RN D then reported Resident #102's concern to Unit Care Coordinator (UCC) F, and wrote the interview/witness statement noted in the previous paragraph.<br><br>Resident #103<br><br>Review of an Admission Record revealed Resident #103 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 7/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #103 was cognitively impaired.<br><br>(continued on next page) |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 8/20/24 at 9:57 AM, Resident #103 reported that there are CNA's on the night shift that are rude and give him a hard time. Resident #103 reported about a specific concern; a couple weeks ago he was having frequent bowel movements during the night and had to press his call light multiple times to have his brief changed, the CNA told him that if he messed his pants again that he would just have to wait for the next shift, because she wasn't going to change him again. Resident #103 reported that he and Family Member (FM) O filled out a complaint form about the CNA with facility, and have not seen that CNA since.<br><br>Review of Resident #103's Concern & Comment Form completed by Resident #103 and Director of Rehabilitation (DOR) J dated 8/2/24 at 10:32 AM revealed, Last week an aide from 3rd shift told him If you go again you are just going to have to wait for 1st shift. At the bottom of the form it was noted, (CNA G Terminated). The form was submitted to this surveyor with the investigation and response portion incomplete, and then resubmitted with the following information on it. Associate receiving concern/comment: (Director of Nursing (DON) B) date: 8/5/24 at 10:00 AM .Investigation findings: employee was found to not provide customer service to (nursing home name) standards .immediate removal from concerned party assignment, employee terminated .<br><br>In an interview on 8/20/24 at 4:07 PM, DOR J reported that Resident #103 and FM O reported the concern regarding a night shift CNA to her, during a therapy session. DOR J did not discuss the concern with anyone, she just completed the concern form and gave it to the DON.<br><br>In an interview on 8/20/24 at 4:00 PM, DON B reported that she had found Resident #103's concern form in her mailbox on 8/5/24 (3 days after it was completed), and did not interpret it as an allegation of abuse or neglect, and did not see a reason to report it to the State Agency.<br><br>Resident #105<br><br>Review of an Admission Record revealed Resident #105 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 6/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #105 was cognitively intact.<br><br>In an interview on 8/21/24 at 10:37 AM, Resident #105 reported that she dreads when the night shift starts because the CNA's are not nice. Resident #105 reported that CNA G says, What do you want? and then acts like she is annoying her when she needs her incontinence brief changed.<br><br>Review of Resident #105's Witness Interview/Statement Form, dated 8/3/24, completed by CNA AA revealed, Incident date/Time 8/3/24 (no time) .Aide told me to not pee anymore so she didn't have to change me.<br><br>In an interview on 8/21/24 at 9:42 AM, CNA G reported that on 8/4/24 she was informed on 8/4/24 by UCC F that she would need to work on the other unit, due to a resident complaint. CNA G reported that she worked for about 5 hours that night and then had to leave due to a family emergency. CNA G reported that she received a phone call the next day, and was terminated from the facility due to multiple resident complaints. CNA G reported that there were several residents that are heavy wetters and are on their call lights a lot during the night.<br><br>(continued on next page) |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 8/21/24 at 3:00 PM, Licensed Practical Nurse (LPN) C reported that she was the manager on call the weekend of 8/2/24-8/4/24, and RN D called her on 8/4/24 to discuss care concerns reported by three residents regarding CNA G. LPN C reported that she had interviewed the staff that had taken the concerns from the residents, and then advised RN D to contact the abuse coordinator, NHA A regarding the concerns. LPN C reported that UCC F was also instructed to pull CNA G aside when she reported for work on 8/4/24, to educate her on customer service expectations. LPN C reported that she did not have the ability to submit a FRI (facility reported incident) to the State Agency, because she did not have a login.<br><br>In an interview on 8/21/24 at 8:00 AM, Nursing Home Administrator (NHA) A reported that CNA G was terminated on 8/5/24, due to not meeting customer service expectations for three residents that had expressed concerns, (Resident #102, #103, and #105). NHA A reported that following the reported concerns, she did not interview other residents, she did not interview staff that worked with CNA G, she did not know if anyone followed up with the residents, and she did not report the residents' concerns to the State Agency. NHA A reported there was no additional information to provide regarding the resident concerns.<br><br>See F600 for additional information. |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027<br><br>This citation pertains to intake #'s MI00145569 & MI00146066.<br><br>Based on interview and record review, the facility failed to thoroughly investigate and protect residents after allegations of abuse were made for 3 residents (Resident #102, #103, and #105) of 6 residents reviewed for abuse, resulting in the alleged perpetrator not being immediately suspended, an incomplete investigation, and the potential for future mistreatment or abuse.<br><br>Findings include:<br><br>Resident #102<br><br>Review of an Admission Record revealed Resident #102 was originally admitted to the facility on [DATE], Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 7/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #102 was cognitively intact.<br><br>Review of Resident #102's a Witness Interview/Statement Form, dated 8/4/24 revealed, .Incident date/time: 8/3/24 NOC (night time) .person conducting interview: (Registered Nurse (RN) D). The following is a statement of the facts as reported by the above-named witness: Aide told me to not pee the bed while putting me on the bedpan. At the bottom of the form it was noted, (Certified Nursing Assistant (CNA) G) Terminated. This document was identified as a Concern/Grievance report, per NHA on 8/21/24.<br><br>In an interview on 8/21/24 at 11:47 AM, RN D reported that she had written the report about Resident #102 because the resident's daughter was in the room, and reported that Resident #102 had been left on the bedpan all night, and then the resident spoke up and stated that Certified Nursing Assistant (CNA) G had told her that she better not pee in bed and then put the bedpan under her. RN D reported that the next day 8/4/24, another resident had reported a concern with CNA G, and that's when she realized that there may be a problem. RN D then reported Resident #102's concern to Unit Care Coordinator (UCC) F, and wrote the interview/witness statement noted in the previous paragraph.<br><br>This surveyor attempted to interview UCC F via phone on 8/21/24 and 8/22/24, with no return call.<br><br>In an interview on 8/20/24 at 8:50 AM, Family Member (FM) L reported that Resident #102 told her that CNA G had been rough with her, yelled at her about wetting in the bed, and left a bed pan under her all night.<br><br>Resident #103<br><br>Review of an Admission Record revealed Resident #103 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 7/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #103 was cognitively impaired.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 8/20/24 at 9:57 AM, Resident #103 reported that there are CNA's on the night shift that are rude and give him a hard time. Resident #103 reported about a specific concern; a couple weeks ago he was having frequent bowel movements during the night and had to press his call light multiple times to have his brief changed, the CNA told him that if he messed his pants again that he would just have to wait for the next shift, because she wasn't going to change him again. Resident #103 reported that he and FM O filled out a complaint form about the CNA with facility, and have not seen the CNA since. Resident #103 reported that CNA K was very stern with him, it was her way or the highway, and CNA K told him that it was against the rules to not wear the facility gowns to bed. Resident #103 reported that he gets warm during the night and had to cut the strings on the gown to get it off, because CNA K tied it so tight.<br><br>Review of Resident #103's Concern & Comment Form completed by Resident #103 and Director of Rehabilitation (DOR) J dated 8/2/24 at 10:32 AM revealed, Last week an aide from 3rd shift told him If you go again you are just going to have to wait for 1st shift. At the bottom of the form it was noted, (Certified Nursing Assistant (CNA) G) Terminated. The form was submitted to this surveyor with the investigation and response portion incomplete, and then resubmitted with the following information on it. Associate receiving concern/comment: (DON B) date: 8/5/24 at 10:00 AM .Investigation findings: employee was found to not provide customer service to (nursing home name) standards .immediate removal from concerned party assignment, employee terminated .<br><br>In an interview on 8/20/24 at 4:07 PM, DOR J reported that Resident #103 and FM O reported the concern regarding a night shift CNA to her, during a therapy session. DOR J did not discuss the concern with anyone, she just completed the concern form and gave it to the DON.<br><br>In an interview on 8/20/24 at 4:00 PM, DON B reported that she had found Resident #103's concern form in her mailbox on 8/5/24 (3 days after it was completed), and did not interpret it as an allegation of abuse or neglect, and did not see a reason to report it to the State Agency. DON B reported that she completed the follow up portion of the concern form on 8/20/24. DON B reported that she would have expected the form be hand carried to NHA A and or DON B, to ensure a timely response to the resident's concern. DON B reported that CNA G was terminated following the complaint investigation, due to attendance concerns within her 90 day probation period.<br><br>Resident #105<br><br>Review of an Admission Record revealed Resident #105 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 6/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #105 was cognitively intact.<br><br>In an interview on 8/21/24 at 10:37 AM, Resident #105 reported that she dreads when the night shift starts because the CNA's are not nice. Resident #105 reported that CNA G says, What do you want? and then acts like she is annoying her when she needs her incontinence brief changed. Resident #105 reported that CNA K is intimidating and told her that she (Resident #105) was not allowed to wear pajamas to bed, and then wakes her up and takes them off of her.<br><br>Review of Resident #105's Witness Interview/Statement Form, dated 8/3/24, completed by CNA AA revealed, Incident date/Time 8/3/24 (no time) .Aide told me to not pee anymore so she didn't have to change me.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER Life Care Center of Plainwell | | STREET ADDRESS, CITY, STATE, ZIP CODE 320 Brigham St Plainwell, MI 49080 | |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 8/21/24 at 9:42 AM, CNA G reported that on 8/4/24 she was informed on 8/4/24 by UCC F that she would need to work on the other unit, due to a resident complaint. CNA G reported that she worked for about 5 hours that night and then had to leave due to a family emergency. CNA G reported that she received a phone call the next day, and was terminated from the facility due to multiple resident complaints. CNA G reported that there were several residents that are heavy wetters and are on their call lights a lot during the night.<br><br>In an interview on 8/21/24 at 3:00 PM, Licensed Practical Nurse (LPN) C reported that she was the manager on call the weekend of 8/2/24-8/4/24, and RN D called her on 8/4/24 to discuss care concerns reported by three residents regarding CNA G. LPN C reported that she had interviewed the staff that had taken the concerns from the residents, and then advised RN D to contact the abuse coordinator, NHA A regarding the concerns. LPN C reported that UCC F was also instructed to pull CNA G aside when she reported for work on 8/4/24, to educate her on customer service expectations. LPN C reported that she did not have the authorization to submit a FRI (facility reported incident) to the state.<br><br>In an interview on 8/21/24 at 4:14 PM, Social Services Director (SSD) I reported that she had not been made aware of Resident #102, #103 and/or #105's reported concerns related to CNA G, and therefore had not followed up with these residents.<br><br>In an interview on 8/21/24 at 8:00 AM, Nursing Home Administrator (NHA) A reported that CNA G was terminated on 8/5/24, due to not meeting customer service expectations for three residents that had expressed concerns, (Resident #102, #103, and #105). NHA A reported that following the reported concerns, she did not interview other residents, she did not interview staff that worked with CNA G, she did not know if anyone followed up with the residents, and she did not report the residents' concerns to the State Agency. NHA A reported there was no additional information to provide regarding the resident concerns.<br><br>See F600 and F609 for additional information. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027<br><br>This citation pertains to intake # MI00146066.<br><br>Based on interview, and record review, the facility failed to ensure care plan interventions were in place per standard of care, to prevent the development of pressure ulcers for 1 resident (Resident #102) of 3 residents reviewed for pressure ulcers, resulting in the development of a Stage 2 pressure ulcer on the right buttock and a deep tissue injury (DTI) on the coccyx.<br><br>Findings include:<br><br>Resident #102<br><br>Review of an Admission Record revealed Resident #102 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: stroke. Resident #102 discharged on [DATE] to the hospital.<br><br>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 7/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #102 was cognitively intact.<br><br>Review of Resident #102's Care Plan revealed no information related to the residents level of assistance with toileting, skin integrity interventions, and/or risk for pressure ulcers.<br><br>Review of Resident #102's Braden Assessments (assessment to predict pressure sore risk) dated 7/10/24 (admission), 7/19/24 and 7/26/24 indicated that the resident was at moderate risk, due to the following factors: Very limited ability to respond to pressure-related discomfort, skin was often very moist, very limited ability to change and control body position, chairfast (cannot walk), a potential problem for skin wounds due to friction and shearing, and urinary and bowel incontinence.<br><br>In an interview on 8/20/24 at 2:59 PM, Licensed Practical Nurse-Unit Care Coordinator (LPN-UCC) E reported that Resident #102 did not have any pressure wounds when she admitted to the facility, and was at moderate risk to develop facility acquired pressure wounds. LPN-UCC E reported that Resident #102 should have had a care plan in place for skin integrity, pressure wound preventions, and/or incontinence care needs while she resided in the facility. LPN-UCC E reported that the expectation was that the nurse who completes the admissions assessment, has the responsibility to develop a baseline care plan immediately, and then the UCC should review the chart to ensure the appropriate care plan and orders were in place based on the resident's admission assessment. LPN-UCC E reported that Resident #102 was incontinent and unable to reposition herself to offload areas of pressure. LPN-UCC E reported that Resident #102 had developed MASD (moisture associated skin damage) on 7/25/24, and then on 8/1/24 a Stage 2 pressure ulcer was identified on her right buttock. LPN-UCC E reported that Resident #102's care plan was not updated to reflect these conditions and the physician did not assess these concerns prior to the resident's discharge. LPN-UCC E reported that there were no additional documentation to support compliance with pressure ulcer prevention.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 8/21/24 at 11:47 AM, Registered Nurse (RN) D reported that Resident #102 had reported being left on the bed pan all night on 8/3/24. RN G reported that MASD (moisture associated skin disorder) had been identified on the resident's buttocks prior to that day, and when she physically assessed the resident, the MASD was still present, but she was unsure if the condition had worsened as a result of being left on the bedpan for an extended period of time.<br><br>In an interview on 8/20/24 at 8:50 AM, Family Member (FM) L reported that Resident #102 told her that CNA G had been rough with her, yelled at her about wetting in the bed, and had left a bed pan under her all night. FM L reported that Resident #102 was not mobile in or out of bed due to a recent stroke, and was incontinent. FM L reported that Resident #102 refused to get out of bed for therapy after developing a bed sore, due to pain from the sore.<br><br>Review of Resident #102s Hospital Records dated 8/5/24 revealed, .Wound Care Note: .right buttock wound stage 2 pressure injury .Coccyx (tailbone) wound, DTI wound that is the size of a dime. Purple in color, no odor, no drainage .<br><br>Review of Resident #102's Wound Note dated 8/1/24 indicated a newly acquired Stage 2 pressure wound on the right buttock.<br><br>Review of Resident #102's Weekly Skin Observation dated 7/25/24 indicated new findings of MASD on buttocks.<br><br>Review of Resident #102's Admission Progress Note dated 7/10/24 revealed, .skin is very thin and fragile. She used the bedpan and needs assist with turns .<br><br>Review of Resident #102's Admission Skin assessment dated [DATE] indicated no MASD, open areas, no wounds, and no areas of friction and/or shearing.<br><br>In an interview on 8/22/24 at 2:49 PM, Director of Nursing (DON) reported that she was not able to find any additional information related to why Resident #102 did not have interventions in place prior to the development of her wounds. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027<br><br>This citation pertains to intake #MI00146066.<br><br>Based on interview, and record review, the facility failed to maintain professional standards of care, and provide adequate incontinence care in 2 of 3 residents (Resident #102 and #106) reviewed for incontinence care, resulting in MASD (moisture associated skin disorder).<br><br>Findings include:<br><br>Resident #102<br><br>Review of an Admission Record revealed Resident #102 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 7/12/24 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #102 was cognitively intact.<br><br>Review of Resident #102's Care Plan revealed no information related to the residents level of assistance with toileting, urinary continence status, skin integrity interventions, and/or risk for pressure ulcers.<br><br>Review of Resident #102's Braden Assessments (assessment to predict pressure sore risk) dated 7/10/24 (admission), 7/19/24 and 7/26/24 indicated that the resident was at moderate risk, due to the following factors: Very limited ability to respond to pressure-related discomfort, skin was often very moist, very limited ability to change and control body position, chairfast (cannot walk), a potential problem for skin wounds due to friction and shearing, and urinary and bowel incontinence.<br><br>In an interview on 8/20/24 at 2:59 PM, Licensed Practical Nurse-Unit Care Coordinator (LPN-UCC) E reported that Resident #102 did not have any pressure wounds when she admitted to the facility, and was at moderate risk to develop facility acquired pressure wounds. LPN-UCC E reported that Resident #102 should have had a care plan in place for skin integrity, pressure wound preventions, and/or incontinence care needs while she resided in the facility. LPN-UCC E reported that the expectation was that the nurse who completes the admissions assessment, has the responsibility to develop a baseline care plan immediately, and then the UCC should review the chart to ensure the appropriate care plan and orders were in place based on the resident's admission assessment. LPN-UCC E reported that Resident #102 was incontinent and unable to reposition herself to offload areas of pressure. LPN-UCC E reported that Resident #102 had developed MASD (moisture associated skin damage) on 7/25/24, and then on 8/1/24 a Stage 2 pressure ulcer was identified on her right buttock.<br><br>In an interview on 8/21/24 at 11:47 AM, Registered Nurse (RN) D reported that Resident #102 had reported being left on the bed pan all night on 8/3/24. RN G reported that MASD had been identified on the resident's buttocks prior to that day, and when she physically assessed the resident, the MASD was still present, but she was unsure if the condition had worsened as a result of being left on the bedpan for an extended period of time.<br><br>(continued on next page) |

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|---|---|
| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 8/20/24 at 8:50 AM, Family Member (FM) L reported that Resident #102 told her that CNA G had been rough with her, yelled at her about wetting in the bed, and had left a bed pan under her all night. FM L reported that Resident #102 was not mobile in or out of bed due to a recent stroke, and was incontinent.<br><br>Review of Resident #102's Weekly Skin Observation dated 7/25/24 indicated new findings of MASD on buttocks.<br><br>Review of Resident #102's Admission Progress Note dated 7/10/24 revealed, .skin is very thin and fragile. She used the bedpan and needs assist with turns .<br><br>Review of Resident #102's Admission Skin assessment dated [DATE] indicated no MASD, open areas, no wounds, and no areas of friction and/or shearing.<br><br>In an interview on 8/22/24 at 2:49 PM, Director of Nursing (DON) reported that she was not able to find any additional information related to why Resident #102 did not have interventions in place prior to the development of her wounds.<br><br>Resident #106<br><br>Review of an Admission Record revealed Resident #106 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 8/3/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #106 was cognitively intact.<br><br>Review of Resident #106's Care Plan revealed, .Focus: .at risk for skin breakdown, infections and altered dignity d/t (due to) has urinary incontinence .Date initiated: 6/13/19. Revision on: 10/10/20 .Interventions: Assist with toileting as needed .Pericare (genitals) as needed. Date initiated 6/13/19. Revision on: 5/7/20 . There were no person centered interventions for incontinence care needs.<br><br>In an interview on 8/21/24 at 11:14 AM, Resident #106 reported that she had developed a painful open area on her buttocks the day before due to her brief not being changed all day. Resident #106 reported that she had her call light on several times throughout that day, and the CNA's kept turning it off and saying that they would be back to change her brief.<br><br>Review of Resident #106's Physician Orders revealed, apply to buttocks for MASD BID two times a day for MASD shearing. Order date: 8/20/24 . There was no medication name listed in the order.<br><br>Review of Resident #106's Incontinence Task Record indicated that the resident was incontinent of urine for 35 of 49 entries over the past 30 days.<br><br>In an interview on 8/21/24 at 3:25 PM, LPN C reported that she was not aware of Resident #106 having MASD concerns until this surveyor brought it to her attention, and to her knowledge the resident was still getting up to use the toilet. After reviewing Resident #106's record, LPN C reported that the resident had orders to apply an unknown topical treatment to her buttocks for MASD, entered by the night nurse the day before. LPN C edited the orders to reflect a topical Zinc (barrier cream) to be applied to the MASD. LPN C reported that standard of care is to check and change every two hours, when an incontinence brief is being used. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027<br><br>Based on interview, and record review, the facility failed to ensure timely monitoring of weight for a newly admitted resident at risk for malnutrition in 1 resident (Resident #105) of 6 residents reviewed for nutrition, resulting in a delay in identifying significant weight loss, and the potential for alteration in nutrition and hydration status.<br><br>Findings include:<br><br>Review of a facility policy, Weight monitoring, long term care dated 8/19/24 revealed, .a resident's weight should be recorded at the time of admission, weekly for 4 weeks, and then monthly .a decrease in weight of 5% or more in a month or of more than 10% in 6 months should be reported to the practitioner for further evaluation .<br><br>Resident #105<br><br>Review of an Admission Record revealed Resident #105 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 6/13/24 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #105 was cognitively intact.<br><br>Review of Resident #105's Care Plan revealed, .Focus: .has nutritional problem or potential nutritional problem r/t (related to) dysphagia (difficulty swallowing) malnutrition, adult FTT (failure to thrive), dementia, anemia, depression .altered texture diet, selective food preferences. Date initiated: 6/10/24. Interventions: . Observe for and report .significant weight loss: 3 lbs (pounds) in 1 week, > 5% in 1 month, >7.5% in 3 months .<br><br>Review of Resident #105's Nutritional Assessment completed by Registered Dietician (RD) R dated 6/10/24 revealed, .Weight: 144.1 (pounds) .Resident with diagnosis of malnutrition and adult failure to thrive .monitor weight.<br><br>Review of Resident #105's Weight Record revealed, 6/9/24 144.1 lbs, 7/1/24 134.3 lbs . Indicating a 6.8% weight loss in 3 weeks. There was no record of weights taken between these two dates.<br><br>In an interview on 8/21/24 at 10:37 AM, Resident #105 reported that she did not like the food at the facility.<br><br>In an interview on 8/22/24 at 10:54 AM, RD R reported that Resident #105 was at known risk for malnutrition upon admission and her weight loss since admission was not planned. RD R reported that ordering weekly weights was up to the nursing staff and she did not know if weights were monitored weekly with newly admitted residents.<br><br>In an interview on 8/22/24 at 11:16 AM, Licensed Practical Nurse (LPN) C reported that newly admitted residents are weighed weekly for 4 weeks to establish a baseline weight and monitor for loss. LPN C reported that nursing staff would not normally weights and that those orders would be strictly based on the dietician recommendations.<br><br>(continued on next page) |

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| | 235471 | A. Building<br>B. Wing | 08/22/2024 |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview on 8/22/24 at 11:26 AM, Director of Nursing (DON) B reported that weights are monitored and recorded upon admission, weekly for 4 weeks and then monthly. DON B reported that the nurse that completes the resident's admission would be responsible for ensuring those orders are in place. DON B reported that Resident #105 did not have weekly weight monitoring orders in place. |