

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  12/17/2025
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Plainwell		STREET ADDRESS, CITY, STATE, ZIP CODE  320 Brigham St 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation is related to intake 2646852. Based on observation, interview, and record review, the facility failed to provide care and services to promote dignity and respect in 3 (Resident #3, #7, and #18) of 18 residents reviewed for dignity/respect, and 4 of 5 residents from the confidential group meeting, resulting in extended call light wait times, unmet care needs and the potential for feelings of diminished self-worth, sadness, and frustration. Findings include: Resident # 3</p> <p>Review of an admission Record revealed Resident #3 was originally admitted to the facility on [DATE] with pertinent diagnoses which included critical illness myopathy (severe muscle weakness and wasting in critically ill patients) and end stage renal disease.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #15, with a reference date of 10/1/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident # 15 was cognitively intact.</p> <p>In an interview and observation on 12/15/2025 at 1:44 PM, This writer knocked on Resident #3's room door. As this writer was entering Resident #3's room, Licensed Practical Nurse (LPN) U walked by this writer and stated, Be careful with him (Resident #3), he is a really cranky person. It was noted that LPN U made the statement about Resident #3 as his room door was open, and she was close enough for Resident #3 to hear her statement.</p> <p>In an interview on 12/15/2025 at 1:44 PM, Resident #3 reported feeling angry and frustrated with the way that staff treated him at the facility. Resident #3 reported that he often had to wait between 30-45 minutes for staff to answer his call light. Resident #3 reported he felt like most of the staff at the facility did not like him, and that he often heard staff talking about him. Resident #3 reported that he had heard staff call him cranky and difficult on several occasions. Resident #3 reported he had talked to facility management about the way that staff had treated him before, but he felt like it made things worse and that staff were retaliating against him, and the facility didn't do anything about his concerns, so he no longer voiced concerns. Resident #3 reported that he was just so tired of being treated like I am a nobody. They don't like me, and they have made that clear.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/16/2025 at 12:01 PM, Nursing Home Administrator (NHA) A reported she was aware that Resident #3 had concerns with staff interactions at the facility. NHA A reported that several staff members had also voiced concerns about interactions with Resident #3. When this writer queried about what the facility had done regarding Resident #3's concerns with staff interactions, NHA A reported she had offered to assist Resident #3 in going to a new facility. NHA A reported that she had not completed any recent education with staff on treating residents with dignity and respect. NHA A reported that Resident #3 was not speaking to NHA A at the time, and that the facility was at a loss at what to do for him.</p> <p>In a follow up interview on 12/17/2025 8:53 AM, Resident #3 reported that he had stopped talking to NHA A because he felt like the facility would not address his concerns and just swept things under the rug. When this writer queried about what kinds of things he had heard staff say about him, Resident #3 cried as he talked about hearing staff say that he was mean, cranky, and not my resident so I am not answering his light. Resident #3 reported he was so tired of being so angry and that he was angry because they just don't even treat me like I am a human being.</p> <p>In a follow up interview on 12/17/25 at 1:45 PM, NHA A reported she expected staff to treat all residents with dignity, and calling a resident cranky was not treating a resident with dignity and respect.</p> <p>Review of the facility's Dignity policy, last reviewed 9/6/25, revealed, Policy: Each resident has the right to be treated with dignity and respect. Interactions and activities with residents by staff, temporary agency staff, or volunteers must focus on enhancing the resident's self-esteem, self-worth, and incorporating the resident's goals, preferences, and choices. Staff must respect the resident's individuality as well as, honor and value their input.</p> <p>Resident #7</p> <p>Review of an admission Record revealed Resident #7 was a female, with pertinent diagnoses which included: hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (stroke) affecting left non-dominant side.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #7, with a reference date of 10/22/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #7 was cognitively intact.</p> <p>Review of Resident #7's current Care Plan revealed a focus of, Resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) Disease Progress (Bipolar Disorder), Impaired mobility and balance last revised 7/29/25 with care planned interventions which included BED MOBILITY: Resident requires assistance by 1 to turn and reposition in bed frequently and as necessary last revised on 11/20/25 and PERSONAL HYGIENE: Resident requires assistance by staff with personal hygiene and oral care last revised 4/28/25.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 12/15/25 at 2:51 PM, Resident #7 reported, on average, it can take at least 30 minutes for staff to answer her call light. Resident #7 explained that because she is paralyzed on one side of her body, she needs help getting boosted up in bed when she wants repositioned. Resident #7 reported when she turns her call light on for assistance and is waiting to get repositioned it is painful. Resident #7 also reported she has had to wait in her soiled brief for an extended period after turning her call light on for assistance and it itches while she is waiting for staff to assist her. Resident #7 reported it makes her sad and angry when she has had to wait extended periods for her call light to be answered.</p> <p>Resident #18</p> <p>Review of an admission Record revealed Resident #18 was a female, with pertinent diagnoses which included: generalized anxiety disorder and major depressive disorder, recurrent, unspecified.</p> <p>Review of a Brief Interview for Mental Status (BIMS) assessment for Resident #18, signed 12/16/25 revealed a BIMS score of 15, out of a total possible score of 15, which indicated Resident #18 was cognitively intact.</p> <p>In an interview on 12/15/25 at 2:30 PM, Resident #18 reported it has taken 30 minutes or more at night for staff to respond to her call light. Resident #18 reported during the day, call light response time was good but at night it takes a long time. Resident #18 reported when it has taken a long time for staff to respond to her call light at night, it made her feel agitated because she would like to go to sleep and would like to see staff for her need before I have to give up. Resident #18 reported it can also take a long time for staff to respond to her call light on the weekend and that sometimes I had my light on forever and nobody would come. Resident #18 reported that was very unpleasant and sometimes she has fallen asleep without having her needs met.</p> <p>In an interview on 12/15/2025 at 4:38 PM, Certified Nurse Aide (CNA) Q reported residents have complained to him about long call light wait times.</p> <p>In an interview on 12/16/2025 at 10:41 AM, Licensed Practical Nurse (LPN) U reported residents have complained to her about long call light wait times, specifically related to night shift.</p> <p>In an interview on 12/16/2025 at 10:44 AM, Registered Nurse (RN) O reported sometimes residents have complained to her about long call light wait times.</p> <p>Review of Resident Council Meeting Minutes for 12/10/25 revealed, .Several residents expressed exceptionally long call light wait times during the evening shift, typically during 8pm - 10pm. Residents expressed waiting over 45 minutes .</p> <p>During a confidential resident council meeting interview held on 12/16/2025 at 1:15 PM, 4 out of 5 residents in attendance were visibly frustrated and reported the average call light wait time on night shift was 30 minutes. The council group reported the delayed call light response wasn't isolated to just one hall but affected four different halls.</p>		