STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235471	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Plainwell	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)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #2973222 and #2976634.Based on interview and record review the facility failed to ensure adherence to a Legal Guardian's right to medication treatment choices for 1 resident (Resident #1) of 1 resident reviewed for Legal Guardian's rights, resulting in Resident #1 being treated and prescribed medications against the wishes of the Legal Guardian. Findings include: Resident #1 (R1)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R1 admitted to the facility on [DATE] with pertinent diagnoses including legal blindness, heart failure, dysphagia (difficulty swallowing), alcohol abuse and kidney disease (kidney are damaged and can't filter blood leading to waste buildup). Brief Interview for Mental Status (BIMS) reflected a score of 6 out of 15 which indicated R1 was severely cognitively impaired. He was discharged to the hospital on 3/19/2026. During an interview on 4/3/2026 at 3:30 PM, Family Member/Guardian (FM) U and FM V stated R1 was unable to make his own decisions and they were his legal guardians. FM V reported that R1 had a bad heart and breathing issues so he was very clear with the facility that he did not want resident to be put on any medication that would sedate him since he had a bad reaction to Trazadone (Desyrel- prescription antidepressant often used to treat insomnia due to its sedating effects) prior to coming to the facility. FM V said that they didn't consent to R1 receiving Quetiapine (Seroquel-antipsychotic used to balance neurotransmitters (regulates mood, sleep, digestion and movement) in the body and can cause drowsiness and cardiovascular risk (heart risk) in the elderly} or Clonazepam (Klonopin-treats panic disorders by calming the nervous system). FM V reported that he was in the building on 3/9/2026 to attend care conference and mentioned that he didn't want R1 to be sedated and drugged.Review of R1's guardianship paperwork dated 7/5/2024 revealed that FM U and FM V were R1's co-guardians.Review of the Hospital Discharge Summary from the hospital to the facility on 3/5/2026 revealed .Medications: quetiapine (seroquel) 50 mg (milligrams) 1 tab (tablet).started on quetiapine for agitation with good response, otherwise medically stable for discharge to long term care at this time. Review of the Medication Informed Consent Form dated 3/6/2026 revealed . prolonged treatment . antipsychotic medication: quetiapine. Dosage: 50 mg (milligrams). Side effects: sedation, drowsiness. It is my decision to: Consent to the use of this medication. Under Resident/Legal Representative it had (no names listed) verbal on the phone. Date 3/6/2026 and was signed by the facility representative. The reason why it was prescribed was left blank. Review of the Medication Informed Consent Form dated 3/12/2026 revealed . Reason why medication was prescribed: Anxiety.prolonged treatment.anti-anxiety medication: clonazepam (Klonopin). Dosage: .25 mg. Side effects: Sedation, drowsiness, ataxia (drunk walk).special attention: if given with other sedatives. It is my decision to: Consent to the use of this medication. Under Name of Responsible Party it listed (FM U) verbal consent. Date discussed 3/12/2026 and was signed by the facility representative {Registered Nurse (RN) C}. Review of the Medication Informed Consent Form dated 3/18/2026 revealed . Reason why medication was prescribed: Anxiety.prolonged treatment.anti-anxiety medication: clonazepam (Klonopin). Dosage: (blank). Side effects: Sedation, drowsiness, ataxia (drunk walk).special attention: if given with other sedatives. It is my decision to: Consent to the use of this medication. Under Name of Responsible Party, it listed (FM U and FM V (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	names). Date discussed 3/18/2026 and was signed by the facility representative (RN F). FM U and FM V did not sign the form. Review of the Order Summary revealed . Quetiapine Fumarate (Seroquel) oral tablet 50 mg, give 1 tablet via tube two times a day for behavior. Order date 3/5/2026 and start date 3/6/2026 . clonazepam oral tablet disintegrating .25mg. Give .25 mg orally two times a day related to primary open-angle glaucoma (eye disease), unspecified eye.order date 3/12/2026. Start date 3/13/2026 (stopped on 3/18/2026).clonazepam oral tablet .5mg. Give .5 mg by mouth two times a day for anxiety. Order date: 3/18/2026. Start date 3/18/2026. Review of R1's progress note dated 3/9/2026 revealed IDT (Interdisciplinary Team) completed initial care conference with the resident's legal guardians. The departments that participated were Nursing, Therapy, Social Services, Activities. IDT addressed all concerns with the family. Social Services completed admissions packet with the legal guardian (FM V) . Review of R1's progress note dated 3/12/2026 revealed New order from {Medical Director (MD) Y} for clonazepam 0.25mg BID (twice a day).Review of R1's progress note dated 3/12/2026 and documented by RN C revealed Late Entry: (written 4/8/2026). This nurse spoke with resident's DPOA (Durable Power of Attorney/Guardian) via phone and received verbal consent to give resident medication. Review of the Physician Progress Note dated 3/18/2026 revealed . I had a conversation with (RN F), nurse in charge at 2:38 PM regarding (R1's) restlessness, being anxious, and behavioral issues. (R1) started on Klonopin .25 mg twice a day on 3/13/2026. (R1's) management was hard and (R1's) Klonopin was increased to .5 mg twice a day.Review of R1's progress note dated 3/18/2026 revealed (MD Y) ordered clonazepam to be increased from 0.25mg bid to 0.5mg bid.Review of R1's progress note dated 3/18/2026 revealed Behavior Note: Spoke with pt (R1) guardian who was apprehensive at first about changing orders on clonazepam from 0.25mg to 0.5mg out of concern that pt would become sedated. After talking to guardian concerning pts care plan, recent behaviors, and upcoming BCS (Behavioral Care Solutions) visit, Guardian stated we will follow the recommendations of the doctor. Psychotropic consent signed and filed.Review of progress note dated 3/19/2026 revealed At 1230 family member (FM V) came in to visit with (R1), came right back out of the room yelling and demanding to know what (medications) he had been given. Stated that he had been given his prescribed medications. Review of progress note dated 3/19/2026 revealed (FM U) called the facility around 1920, wanting to know what my name was and if I was the nurse caring for (R1) this morning? I stated that I was. She also wanted to know when he was started on the Clonazepam, answered her questions. She phoned again at 2000, asking similar questions.During an interview on 4/8/2026 at 2:48 PM, RN C stated he put the initial order for Klonopin since the doctor wanted it and he called FM U and she gave verbal consent for it but FM V said he didn't want R1 on it and didn't want him drugged up. RN C said that FM U said she would agree to the doctor treating him but didn't want him sedated. When asked why he put a progress note in on 4/8/2026 regarding his conversation with FM U on 3/12/2026, RN C stated that he was told by Director of Nursing (DON) B to put a note in that day. During an interview on 4/8/2026 at 3:00 PM, Social Services Director (SSD) T stated that the unit managers were getting medication consents from residents/families before and now he was involved with it. When discussing the care conference on 3/9/2026, SSD T said that FM U and FM V didn't say anything about not putting R1 on psychotropic medications (medications that affect brain function, used to treat mental health conditions). During an interview on 3/8/2026 at 3:17 PM, RN F stated that he filled out the medication consent form for the Klonopin increase to .5 mg on 3/18/2026 due to anxiety since Seroquel and the Klonopin dose of .25 mg wasn't working. RN F reported that he called FM V and he was reluctant about increasing it since he didn't want R1 to be sedated. During an interview on 4/8/2026 at 4:35 PM, MD Y stated that he couldn't remember R1 or his recommendation to increase the Klonopin. During an interview on 4/9/2026 at 12:20 PM, DON B stated that on 4/8/2026 she asked RN C to hand write a note regarding R1's Klonopin consent on 3/12 but he put it in the progress note instead. DON B reported that her expectations for a medication consent was that a verbal consent had to be documented on the form with the name, medication, dose, yes or no to the consent and either the resident or the DPOA/guardian name of who they talked to. DON B stated that (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they were unable to get a physical signature from FM U or FM V since they didn't come to the facility much and once they get a verbal signature, they didn't get a physical signature. When discussing that FM V discussed at the care conference at the facility on 3/9/2026 that he did not want R1 sedated, DON B said she wasn't aware of it. Review of the visitor log revealed that FM U and FM V visited R1 at the facility on 3/9/2026 and 3/19/2026.During another interview on 4/9/2026 at 11:20 AM, FM U and FM V stated again that the facility did not contact them on 3/6/2026, 3/12/2026 or 3/18/2026 regarding medication consents for Seroquel and Klonopin. FM V said that he told the facility even with behavior problems he did not want R1 sedated. FM V stated he agreed to the physician treating R1 and orders the physician would put in but did not agree to him getting Seroquel or Klonopin.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify resident's guardians regarding a fall for 1 resident (Resident #1) of 3 residents reviewed for falls resulting in Resident #1's guardians being unaware of the fall and if any injuries occurred. Findings include: Resident #1 (R1)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R1 admitted to the facility on [DATE] with pertinent diagnoses including legal blindness, heart failure, dysphagia (difficulty swallowing), alcohol abuse and kidney disease (kidney are damaged and can't filter blood leading to waste buildup). Brief Interview for Mental Status (BIMS) reflected a score of 6 out of 15 which indicated R1 was severely cognitively impaired. He was discharged to the hospital on 3/19/2026. Review of R1's guardianship paperwork dated 7/5/2024 revealed that Family Member/Guardian (FM) U and FM V were R1's co-guardians.Review of R1's Progress note dated 3/18/2026 revealed . (R1) was found on his knees facing his bed with his oxygen and tube feed tube (tube that provides artificial nutrition directly into the stomach or small intestine) wrapped around him at 0640. Assessed for injuries, none noted, helped back into bed, tubing straightened out and vitals/neuros (neuro checks-assess for brain injury or increased intracranial pressure) started. Continued with his fast breathing, B/Ps (blood pressure) were high in the beginning, but came down throughout the day. called out frequently, addressed needs as they presented, no complaints of pain and no bruising noted to knees.Review of R1's fall report dated 3/18/2026 revealed . Nursing Description: Resident observed sitting on his knees leaning over his bed. Tube feeding (provides artificial feeding into the stomach or small intestine) and foley (tube) in place. Was not wearing nasal cannula when nurse entered the room. PT (patient) was restless and dressing and was exhibiting compulsory behavior of calling out and self transferring from chair to bed and bed to chair, despite staffing encouragement to allow staff to assist pt.Agencies/People Notified: Physician (Medical Director (MD) Y) , DON (Director of Nursing B) It was not documented that the family was notified. During an interview on 4/8/2026 at 12:20 PM, RN H stated that she worked on 3/18/2026 when R1 was found on his knees. RN H reported that she assumed he fell and she couldn't remember if she notified his guardians but she notified the physician and DON B. During an interview on 4/8/2026 at 11:50 PM, FM U and FM V stated that they were unaware of R1's fall on 3/18/2026 since the facility did not notify them. FM V was surprised that R1 fell and that no one contacted him about it. Review of the Changes in Resident Condition or Status Policy with a review date of 8/29/2025 revealed .Federal Regulations: Notification of Changes: (i) A facility must immediately inform the resident,; consult with the resident's physician and notify consistent with his or her authority, the resident representatives when there is an accident involving the resident which results in injury and has a potential for requiring physical physician intervention.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #2973222 and #2976634.Based on interview and record review the facility failed to ensure that a resident's behavior was managed and interventions were put in place prior to starting a chemical restraint affecting 1 resident (Resident #1) of 1 resident reviewed for medication management resulting in Resident #1 being prescribed Seroquel {antipsychotic used to balance neurotransmitters (regulates mood, sleep, digestion and movement) in the body and can cause drowsiness and cardiovascular risk (heart risk) in the elderly} upon admission and then adding Klonopin (treats panic disorders by calming the nervous system) to help manage behaviors. Findings include: Resident #1 (R1)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R1 admitted to the facility on [DATE] with pertinent diagnoses including legal blindness, heart failure, dysphagia (difficulty swallowing), alcohol abuse and kidney disease (kidney are damaged and can't filter blood leading to waste buildup). Brief Interview for Mental Status (BIMS) reflected a score of 6 out of 15 which indicated R1 was severely cognitively impaired. He was discharged to the hospital on 3/19/2026. Review of the Order Summary revealed . Quetiapine Fumarate (Seroquel) oral tablet 50 mg, give 1 tablet via tube two times a day for behavior. Order date 3/5/2026 and start date 3/6/2026 . clonazepam oral tablet disintegrating .25mg. Give .25 mg orally two times a day related to primary open-angle glaucoma (eye disease), unspecified eye.order date 3/12/2026. Start date 3/13/2026 (stopped on 3/18/2026).clonazepam oral tablet .5mg. Give .5 mg by mouth two times a day for anxiety. Order date: 3/18/2026. Start date 3/18/2026. Review of R1's 30-day behavior lookback documentation that Certified Nursing Assistants (CNAs) complete revealed 2 days of documenting behaviors regarding disruptive sounds.Review of R1's care plan revealed . Focus: (R1) has a behavioral problem where he will drink water out of his/roommate's urinal. (R1) has a history of being non-compliant with fluid restriction related to drinking water and drinking out of roommates in his own urinal. (R1) also was observed drinking out of the toilet.Intervention/Tasks: Anticipate and meet the resident's needs. Educate (R1)/family/caregivers on successful coping and interaction strategies such as (Specify). The resident needs encouragement and active support by family/caregivers when the resident uses these strategies. Date initiated 3/6/2026. There were no intervention strategies listed for R1. Review of R1's progress noted dated 3/6/2026 revealed Behavior Note: DON (Director of Nursing B) and social worker {Social Services Director (SSD) T} contacted the residents POA (Power of Attorney/Guardians) to speak with about resident's noncompliance with NPO/ no drinking liquids. DON and Social Worker spoke about the importance of the resident being adherent to the NPO order. POA states he will come to the initial care conference on 3/9/26. Social Services and IDT will follow up as needed to ensure the resident's safety.Review of R1's progress note dated 3/6/2026 revealed Behavior Note: Pt (patient) keeps drinking out of the sink even though he's NPO and we keep reminding him. His roommate said that he drank out of his (the roommate's) water basin. He also keeps pulling on his G-Tube (gastrostomy tube placed for feedings, fluids and medication when oral intake is not possible) and it is getting really red and we keep reminding him not to.Review of R1's progress note dated 3/8/2026 revealed Patient was wheeling self to sink to get a drink and tube feeding (artificial feeding that goes to the stomach) pole fell over. When reminded he is not supposed to have anything to drink he became upset with rapid breathing. Offered to get swab to perform oral care and he declined saying he did not want to brush his teeth he wants to drink.Review of R1's progress note dated 3/8/2026 revealed Walked by room and found patient at sink, TF (tube feeding) pole on floor, roommate visitor states he has been at the sink for about 10 minutes drinking water. Patient said he is thirsty and is not going to stop.Review of R1's progress note dated 3/9/2026 revealed IDT (Interdisciplinary Team) completed initial care conference with the resident's legal guardians. The departments that participated were Nursing, Therapy, Social (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Services, Activities. IDT addressed all concerns with the family.Review of R1's progress note dated 3/9/2026 revealed Patient yelling out most of day. Staff assists patient and when they leave the room, he immediately starts yelling out again. Patient given a tablet from activities to watch music videos and listen to music he likes. Since the tablet has been in his room he has not yelled out. Noted large amount of sputum on floor around patient. Patient spitting on floor. He was given a basin to spit in, and he continues to spit on the floor.Review of R1's progress note dated 3/10/2026 revealed Behavior Note: Resident awakened at approximately 0230-0300am (2-3 AM) and began to holler out, hey hey hey each time staff enters his room, he is requesting to go outside. Unable to assist resident outside at this time. Instructed resident that more staff will be present later in AM and this may be possible, but not at this time. He lies back down a short time, than begins again. Same process. Oriented to call light. Will continue to monitor.Review of R1's progress note dated 3/10/2026 revealed Resident pulled out G-tube. Review of R1's progress note dated 3/10/2026 revealed Skilled note: Repeated calling out Hey asking everyone who will listen if they get him ice chips or water. Has a tube with continuous feeding going at 64ml's per hour with 35ml's of water flush per hour. He pulled out his tube this morning around 0650, a Foley catheter was placed in the interim. An appointment was made for tomorrow to replace the feeding tube (provides artificial feeding into the stomach or intestine). resident is alert and oriented to self, able to make some needs known, staff to anticipate needs at times. resident has peg tube, is on continuous feeding and is NPO. V/S WNL. no s/s of pain or discomfort and he denied pain. pt pulled g-tube out, has appointment to have replaced on 3/11/26. Pt on 2l o2 and removed o2 at times then becomes tachypneic and drops spO2 down to low 80's. once O2 is replaced, spo2 climbs back to 90's. Constan calling out, regardless of repeated education on not being able have ice chips and or water, he continues to ask anyone who will listen. Does not use call light, just yells out.Review of R1's progress note dated 3/11/2026 revealed Patient returned from hospital from having PEG tube inserted. Patient refusing to start tube feeding, wants to push self around hallway. Review of R1's progress note dated 3/11/2026 revealed Resident asked this nurse for a glass of water, this nurse informed resident that the doctor has resident's diet as nothing by mouth, resident said ok, moments later resident again asked this nurse for some water, this nurse informed resident that he just asked for water and was told the about his diet order, resident said no you didn't. this nurse again informed resident that he was NPO, resident within moments again asked this nurse for some water.Review of R1's progress note dated 3/11/2026 revealed Patient in his room listening to music. RN asked patient if tube feeding could be started and patient states he wants water first. When instructed that the physician has an order not allowing any intake by his mouth. Patient started screaming and would not allow tube feeding to be restarted.Review of R1's progress note dated 3/12/2026 revealed Saw pt in the hallway holding on to his bedside commode, walked down there to help him and see his oxygen was around his waist, his feeding pump was knocked over on the floor and his g-tube was on the floor next to it. I asked him if his stomach hurt where it got pulled out and he said no. helping him get his oxygen back on, picked up his feeding pump and put a bandage on his stoma. {Registered Nurse (RN) F} was notified.Review of R1's progress note dated 3/12/2026 revealed New order from {Medical Director (MD) Y} for clonazepam 0.25mg BID.Review of R1's progress note dated 3/13/2026 revealed IDT (Interdisciplinary Team)/ Behaviors: [NAME] is impulsive, g-tube dislodged times 2, drinking from sink in room, from toilet, water turned off in room per guardian request. Hand hygiene per hand sanitizer. Room is across from shower room, which is used for all hygiene for (R1). Can have small amount if ice chips supervised. Continuously asks for water.Review of R1's progress note dated 3/13/2026 revealed IDT/RAR (Resident at Risk): Pt has dislodged g-tube 2 times in 2 days. Pt is restless and anxious. Calls out frequently and rolls his w/c (wheelchair) around totally unaware of being connected to 24 hour tube feed. Intervention to prevent further dislodgment is to use stat (immediate) lock, applied pole to w/c to hold pump and tube feed. Review of R1's progress note dated 3/18/2026 revealed Behavior Note: pt continues to yell out, hey, hey, hey all throughout the day for hours at a time. Pt asks to be put to bed, and then minutes later (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will ask to be put back in w/c, and vice versa. Pt often attempts to transfer self to and from bed, several times an hour. Pt also has poor spacial awareness lending to tugging on g-tube and nasal cannula (tube put on nostrils that delivers oxygen) when propelling self in w/c. IV (intravenous pole that you hang bags of tube feeding and fluids) pole installed on w/c to prevent this. (MD Y) notified.Review of R1's progress note dated 3/18/2026 revealed (MD Y) ordered clonazepam to be increased from 0.25mg bid to 0.5mg bid.Review of the Physician Progress Note dated 3/18/2026 revealed . I had a conversation with (RN F), nurse in charge at 2:38 PM regarding (R1's) restlessness, being anxious, and behavioral issues. (R1) was started on Klonopin .25 mg twice a day on 3/13/2026. (R1's) management was hard and (R1's) Klonopin was increased to .5 mg twice a day.During an interview on 4/9/2026 at 11:20 AM, Family Member/Guardian (FM) U and FM V stated that the facility did call them regarding R1's behaviors but they did not ask them about non-pharmacological interventions that they could try to help decrease these behaviors. FM V reported that there was a care conference meeting on 3/9/2026 where they discussed R1's status and he told the facility even with behavior problems he did not want R1 sedated. During an interview on 4/8/2026 at 8:25 AM, RN G stated that R1 had behaviors daily which included yelling out, noncompliance with NPO (nothing by mouth) status since he drank water from the sink and toilet, and he pulled his feeding tube out several times. RN G didn't know of any interventions besides checking on him. During an interview on 4/8/2026 at 12:20 PM, RN H stated that R1 called out all the time and would try to get the attention of staff. RN H reported that he constantly wanted water but he was unable to have it and he pulled his feeding tube out several times. During an interview on 4/8/2026 at 1:35 PM, RN I stated that R1 had behaviors daily such as drinking water despite his NPO status and trying to pull out his feeding tube. She did not know of any known interventions that worked. RN G didn't know of any interventions besides checking on him.During an interview on 4/8/2026 at 2:48 PM, RN C stated that R1 hollered a lot saying Hey, hey, hey and yanking on his feeding tube. RN C also reported that R1 was non-compliant with his oxygen and NPO status. RN C said Klonopin was started on 3/12/2026 because of R1's behaviors and anxiety. During an interview on 4/8/2026 at 3:00 PM, Social Services Director (SSD) T stated that R1 called out all the time and even when his needs were met. SSD T stated they had a care conference on 3/9/2026 with FM U and FM V where they discussed resident status. During an interview on 4/8/2026 at 3:17 PM, RN F stated that R1 had repetitive behaviors with calling out constantly, self-transferring, pulling out his tube and he could not be educated due to his cognition. RN F' stated R1 was started on Klonopin on 3/12/2026 and then it was increased on 3/18/2026 due his behaviors and anxiety. During an interview on 4/8/2026 at 4:35 PM, MD Y stated that he couldn't remember R1 or his recommendation to increase the Klonopin. During an interview on 4/9/2026 at 12:20 PM, Director of Nursing (DON) B stated that R1 was challenging and impulsive with poor safety awareness. DON B said he pulled off oxygen, pulled out his feeding tube several times and would drink water when he was NPO. When discussing that R1's care plan didn't list any interventions and what non-pharmacological interventions staff tried to help decrease his behaviors, DON B' said they tried multiple interventions such as activities and checking on him regularly. DON B said that FM U and FM V weren't realistic about R1's limitations and prognosis. Review of the Psychotropic Medication Use Policy with a revision date of 3/1/2025 revealed . Procedure: The facility should not use psychotropic medications to address behaviors without first determining if there is a medical, physical, functional, psychological, social or environmental cause of the resident's behaviors.2.1.1. Facility staff should take a holistic approach to behavior management that involves A thorough assessment of underlying causes of behaviors and individualized person centered non drug and pharmaceutical interventions. 2.1.3 staff should become familiar with the cultural, medical, and psychological information about the resident to identify potential environmental and other triggers to prevent or reduce behavioral symptoms and/or distress types and the consequences of behaviors exhibited by the resident and interventions that may be indicated for specific behavior type.3. Facility should involve the resident or the resident representatives in the discussion of potential (continued on next page)

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	235471	A. Building B. Wing	04/09/2026

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Life Care Center of Plainwell	320 Brigham St Plainwell, MI 49080

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nonpharmacologic and medication interventions to address the management of behaviors and the involvement should be documented in the residence medical record. 3.1 Psychotropic medications may be used to address behaviors only if non drug approaches and interventions were attempted prior to their use. 3.2. Psychotropic medications to treat behaviors will be used appropriately to address specific underlying medication or psychiatric causes of behavioral symptoms.9. Where physician/prescriber orders a psychotropic medication for a resident facility should ensure physician prescriber has conducted a comprehensive assessment of the resident and has documented in the clinical record that the psychopharmacologic medication is necessary.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2960916.Based on interview and record review the facility failed to maintain quality of care by ensuring implementation of skin care treatment and ensure skin care was completed for 1 resident (Resident #2) of 3 residents reviewed for quality of care resulting in dressing changes not being implemented and being monitored causing unmet resident care needs. Findings include: Resident #2 (R2)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R2 admitted to the facility on [DATE] with pertinent diagnoses including morbid obesity, difficulty walking, heart failure and chronic pain. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R2 was cognitively intact. She had a planned discharge to the hospital on 3/27/2026. During an interview on 4/8/2026 at 1:57 PM, R2's Family Member (FM) W stated that R2 received skin tears from her fall on 3/9/2026. FM W said when she was in the facility on 3/21/2026 she noticed the bandage on her left arm was dated 3/10/2026 and it wasn't changed until she mentioned it to the nurse that day. FM W reported that R2's arm got worse and was weeping. Review of R2's Fall report completed by Registered Nurse (RN) F and dated 3/9/2026 revealed Resident was getting assistance from the CNA (Certified Nursing Assistant) to go to the hospital. While the CNA was transferring the resident to the toilet the resident stated that she was feeling dizzy. CNA stated the resident was lowered to the floor and as soon as she was on the floor the CNA said the resident was safe on the floor and came to get this nurse. Injuries: back of left hand, right elbow, back of right hand. Review of R2's Care Plan revealed Focus: The resident has skin tear, fragile skin. Date initiated 1/9/2026.Interventions/Tasks.Use caution during transfers and bed mobility to prevent striking arms, legs and hands against any sharp or hard surface. Date initiated 1/9/2026. Review of R2's progress note dated 3/9/2026 revealed Resident was getting assistance from the CNA to go to the hospital. While the CNA was transferring the resident to the toilet the resident stated that she was feeling dizzy. CNA stated the resident was lowered to the floor and as soon as she was on the floor the CNA said the resident was safe on the floor and came to get this nurse. Nurse assessed residents' vitals and blood pressure was 74/54 with a pulse of 42. Resident obtained a skin tear to bilateral upper arms. Resident was not harmed during the transition from standing to lowering. Resident was assisted back to bed via hoyer lift x 3 staff members. She was positioned back into bed to her liking. Physician will be notified of blood pressure.Review of R2's Physician progress note dated 3/16/2026 revealed Reason for Evaluation: I am asked by nursing staff to evaluate the patient/s (R2's) left arm swelling. Subjective: This is an [AGE] year-old white female. The patient was on the other side of the unit and the nurses knew about the patient's swelling. The redness is better but the patient is developing a little bit more fluid now. Assessment: Arm swelling. Plan: 1. Will start the patient on Bumex (diuretic-gets rid of fluid) again one time a day. 2. Observation.Review of provider progress note dated 3/21/2026 revealed .History Present Illness : Patient sustained a fall last week. Skin tear was treated on left forearm. Dressing had not been changed since and today when removing, tear reopened. Does have moderate bleeding noted, on Eliquis. Area is reddened and bruised throughout entire forearm.Review of progress note dated 3/23/2026 revealed Discussed care concerns with (FM W). Will talk to (MD Y) this afternoon when he is in facility about L (left) arm swelling and weeping, and changing pain medication from scheduled from prn (as needed) since she forgets to ask and then is in a lot of pain. Discussed wound care orders for skin tears on arms.Review of R2's progress note dated 3/25/2026 revealed This wound is a skin tear from blisters opening on the forearm from fluid overload in this left arm due to her heart failure. This arm is dependent and needs to be elevated at all times as the resident will allow, provider is following this closely and there has been lab work ordered and medication changes ordered to try and treat the symptoms of the heart failure.Review of R2's weekly skin assessment and wound observation assessment did not address R2's skin tear that occurred on 3/9/2026 until (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/22/2026. Review of R2's March 2026 Treatment Assessment Record (TAR) revealed Wound care-right forearm: spray with wound cleanser, pat dry with gauze, apply xeroform to both proximal (closest to skin tear area) and distal (farther away from the skin tear), cover with 4x 4 green foam silicone dressing, change every other day and prn (as needed) for soiled, loose or missing dressing. Order date 3/23/2026. Wound care-right forearm: spray with wound cleanser, pat dry with gauze, apply xeroform to both proximal and distal skin tear, cover with 4x 4 green foam silicone dressing, change every 3 days for soiled, loose or missing dressing. Order date 3/23/2026.Wound care to left forearm. Cleanse with normal saline, pat dry, betadine paint, cover with non adherent pad, then 4 by 4 over the non-adherent pad, secure with coban with light pressure (lightweight, breathable elastic wrap that only sticks to itself). Every day shift for skin tear. Drainage-N-None, S-serous (clear, thin, watery), Se-Serosangious (thin, watery, pinkish red discharge), B-Bloody, P-Purulent (thick, cloudy and foul smelling), Odor-Y-Yes, N-No. Periwound (area surrounding wound)-P-Pink, R-Red, I-Indurated (hard tissue), W-Warm, Wound Bed-G-granulation (new tissue forming during wound healing), S-Slough (dead tissue separating from living skin) , E-Eshar (dead tissue), Ep-Epithelialization (new skin cells on a wound), Wound outcome-U-Unchanged, I-Improved, D-Deteriorated. Order date 3/21/2026. The first treatment was started on 3/24/2026.Review of R2's shower sheet completed by CNA R on 3/18/2026 revealed documentation on the person diagram Left bandage was stuck on skin and smelled bad. During an interview on 4/8/2026 at 9:18 AM, CNA P' stated that on 3/21/2026 R2's left arm bandage was nasty since the nurses didn't change it in a while so she told the nurse about it that day so she could change it. CNA P reported that R1's bandage was weeping through and was black/brownish in color. During an interview on 4/8/2026 at 3:17 PM, RN F' stated that resident had skin tears on her arms from the fall on 3/9/2026 and 1 arm was weeping but he didn't know which one. RN F stated that he was the wound nurse on his unit and he ensured treatments were in place for skin tears. RN F' stated that he did weekly wound rounds but didn't think he did one with her because she moved to the other hall and Licensed Practical Nurse (LPN) J is the unit manager on that side. Review of the facility census report revealed that R2 switched rooms and units on 3/16/2026. During an interview on 4/8/2026 at 3:56 PM, LPN J' stated that she only saw R2's wound 1 time with Medical Director (MD) Y since R2 was new to her unit. LPN J' stated the left arm skin tear looked like a blister when she saw it. LPN J also reported that she only saw wounds such as pressure ulcers and not skin tears or other skin areas. LPN J said that usually a nurse would find a skin area or CNAs would tell her and then a treatment was put in place. During an interview on 4/8/2026 at 4:07 PM, CNA R stated that she gave R2 a shower on 3/18/2026 and she tried to take the bandages off her left arm but it was stuck, stinky and looked like it wasn't changed for a while. So, she notified the nurse. During an interview on 4/8/2026 at 4:35 PM, MD Y stated that he couldn't remember R2 and her skin tear on her left arm. During an interview on 4/9/2026 at 9:23 AM, LPN L stated that she was the nurse on duty when R2 fell on 3/9/2026. LPN L said that R2 scrapped both her arms on the side of the toilet when she was lowered to the ground by the CNA. LPN L' didn't remember getting treatment orders from the physician for her skin tears. During another interview on 4/9/2026 at 9:46 AM, RN F stated that he prepared the fall report on 3/9/2026 and he should have obtained treatment orders at that time. When discussing the fact that the TAR did not have any orders from 3/9/2026 when the fall and skin tears occurred until 3/21/2026 when an order was put in, RN F said I got busy and it got missed. It's on me.During an interview on 4/9/2026 at 12:20 PM, Director of Nursing (DON) B stated that she was unaware of R2's skin tears and having no treatment orders and she said to ask RN F about it. DON B stated that the normal process was to notify the doctor for skin issues, get a treatment and follow the orders and monitor the wound. Review of the Skin Care and Wound Management Policy with no date revealed .6. If any new skin alteration/wound is identified, it is the responsibility of the nurse to perform and document as assessment/observation, obtain treatment orders, and notify MD (Medical Doctor) and responsible party.7. Orders are required for wound dressings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, facility staff failed to wear appropriate PPE (personal protective equipment) for 1 resident (Resident #5) of 4 residents reviewed for infection control practices resulting in the potential for the spread of disease in a vulnerable population.Findings include: Resident #5(R5)Review of R5's orders revealed Isolation: Contact and Droplet Precautions, Diagnosis: RSV. Directions every shift. Start date 4/7/2026.Review of R5's progress notes dated 4/7/2026 revealed RSV positive results received. Isolation precautions per policy.During an observation on 4/8/2026 at 8:25 AM outside R5's room, the following signs were noted: Enhanced Barrier Precautions and Droplet Precautions. The Enhanced Barrier Sign displayed Stop: Everyone must clean their hands, including before entering and when leaving room. Providers and staff must also: Wear gloves and a gown for the following high contact resident care activities: dressing bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing. Do not wear the same gown and gloves for the care of more than one person. The droplet precaution sign displayed Stop: Everyone must: Clean their hands, including before entering and when leaving the room. Make sure eyes, nose, mouth are fully covered before room entry. Remove face protection before room exit.During an observation on 4/8/2026 at 8:33 AM, Infection Preventionist (IP) E walked into R5's room with only a mask on and when she came out, she had the same mask on and continued to walk down the hallway. During an interview on 4/8/2026 at 8:40 AM, IP E stated that she was new in the position and was learning. IP E said that R5 has RSV (Respiratory Syncytial Virus) and the signs were put up so staff knew what PPE to wear. When discussing the appropriate PPE to wear in a RSV positive room, IP E stated that she should have worn a gown, gloves and changed out her mask. IP E stated that she was only in the room for a few minutes and didn't think about PPE. During an observation on 4/8/2026 at 8:50 AM, IP E put a contact precautions sign up on R5's door along with the other signs which displayed Everyone must clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use and another person. During another interview on 4/9/2026 at 9:10 AM, IP E stated that RSV should have both contact and droplet precautions signs which included wearing a gown, gloves, mask but eye protection was optional.During an interview on 4/9/2026 at 12:20 PM, Director of Nursing (DON) B stated that IP E felt bad about walking into R5's room without the appropriate PPE. DON B reported that with RSV it included contact and droplet precautions which included a gown, gloves, mask and eye wear was optional. DON B stated that the droplet sign was put on the door to make sure staff changed their mask out when leaving the room. DON B reported that eye wear was available at the nurses' station if anyone wanted to wear it.