STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235637	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Ave 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 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 This citation pertains to intakes: MI0014331, MI00143140, MI00142071, MI00139687, and MI00144696 Based on observation, interview, and record review, the facility failed to protect residents rights to be free from mental abuse, verbal abuse, and physical abuse by staff and other residents in 5 of 8 residents' (Resident #101, Resident #103, Resident #105, Resident #106, and Resident #107) reviewed for abuse, resulting in Findings include: Resident #101: Review of an Admission Record revealed Resident #101, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia without behavioral disturbance, aphasia (deficit with verbally expressing self) delusional disorder, psychotic disorder, and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 3/16/24 revealed a Brief Interview for Mental Status (BIMS) score of 0/15 which indicated Resident #101was severely cognitively impaired. Review of a Care Plan for Resident #101 dated 11/28/23 revealed a problem/goal/approach: (Resident #101) displays .behavioral symptoms that impact her by putting her at risk for physical injury .interferes with social interactions .disrupts living environment .Goal: (Resident #101) will not cause harm to residents, staff, self . Approach: Resident placed 1:1 from after lunch until bedtime .maintain calm environment and approach to resident .when resident becomes physically abusive .report to DON (Director of Nursing) Administrator . chart in behavior log. Review of a Incident Investigation Report dated 3/5/24 revealed on 2/25/24 at 2:54pm Certified Nursing Assistant (CNA) L reported to Nursing Home Administrator (NHA) A that she witnessed Resident #101, who was seated on the floor of the hallway wearing only a gown and brief, being pulled backwards down the hall by Registered Nurse (RN) T at 1:30am. Further review of the report revealed RN T admitted he pulled Resident #101 down the hall as she sat on the floor and had done so previously as well. Resident #101 received a skin tear on her buttocks because of RN T's actions. (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 0600 Level of Harm - Actual harm Residents Affected - Some	Review of a facility floor plan included in the facility's investigation file for the event that took place involving Resident #101 on 2/25/24 revealed a handwritten identification of the location in which the dragging of Resident #101 by RN T started and stopped. In an observation, the area in which Resident #101 was dragged measured a total distance of 70', 45' on a floor covered with a low pile carpet, and 25' on a tiled floor. Review of a Skin Observation Report dated 2/25/24 revealed Resident #101 had a new circular open wound on her left buttock that measured 2 centimeters in width. In an interview on 5/8/24 at 1:01pm, CNA L reported on 2/25/24 at 1:30am she saw Resident #101 crawling toward the end of the hall on the carpeted floor, wearing a hospital gown and brief. CNA L reported Resident #101 had been resistant to direction that night. CNA L reported she observed Registered Nurse (RN) T retrieve and gait belt and walk toward Resident #101 as she crawled on the floor, facing away from RN T. CNA L followed because she assumed RN T was going to help Resident #101 stand up and 2 staff members would be needed. CNA L reported RN T walked up behind Resident #101, placed the gait belt across her chest with both ends of the belt behind the resident and then pulled forcefully causing Resident #101's body to drag on the floor as RN T walked backwards. CNA L reported RN T dragged Resident #101 70' until he released her body near the nurse's station. CNA L reported she told RN T to stop as he dragged Resident #101 because she was concerned Resident #101 was going to get hurt, but he refused. CNA L reported Resident #101 cried as result of the event and although she had difficulty verbally expressing herself, Resident #101 repeatedly said You don't love me anymore and Ouch as she sat on the floor, cried, and rubbed her buttocks while rocking side to side. CNA L reported she witnessed an abrasion and a bruise Resident #101's buttocks. CNA L reported she felt the actions of RN T were abusive but did not feel safe to report the situation while working alone with RN T. In an interview on 5/8/24 at 2:58pm, Certified Nursing Assistant (CNA) K reported she heard RN T say to Resident #101 Shut up no one is talking to you several times when Resident #101 spoke after hearing others talk. CNA K reported she told former Director of Nursing (FDON) C that RN T was verbally abusive to residents, gave her the example of the statements she heard him say to Resident #101, and FDON C replied Oh that's just (RN T's name omitted). In an interview on 5/16/24 at 11:57am, former Certified Nursing Assistant CNA BB reported in the months leading up to the event that took place with Resident #101 on 2/25/24, CNA BB heard RN T verbally threaten to stomp on Resident #101 as she laid on the floor. In an interview on 5/10/24 at 9:54am, Guardian U (legal guardian of Resident #101) reported the abusive actions of RN T on 2/25/24 were dehumanizing and demoralizing for Resident #101. Guardian U reported a reasonable person who experienced that type of treatment would experience fear, frustration, and extreme stress related to being unwillingly dragged 70' by a care provider. In an interview on 5/10/24 at 10:48am, CNA L reported she witnessed another event prior to 2/25/24 in which RN T forcefully pushed Resident #101 from a standing position into a nearby wheelchair, and then lowered her onto the floor. The forceful nature of RN T's actions caused Resident #101 to yell out in fear. CNA L reported RN T appeared frustrated during his actions and it appeared abusive, so she told former Director of Nursing (FDON) C, but FDON C responded with she's care planned for it (being on the floor) so it's fine. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of RN T's employee file revealed no corrective action related to potentially abusive behavior was taken prior to the event that occurred on 2/25/24. Using the reasonable person concept, though Resident #101 had decreased ability to verbally express her own thoughts due to her cognitive deficits, she clearly experienced emotional distress and pain following the physical abuse that occurred on and prior to 2/25/24. This emotional distress has the potential to continue well past the date of the incident based on the reasonable person concept. Resident #101's court appointed guardian confirmed that the abuse she endured caused psychosocial harm. Resident #103 Review of an Admission Record revealed Resident #103, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: nontraumatic acute subdural hematoma (bleeding between the brain and it's outermost covering), depression, weakness, post-polio syndrome (disorder of the nerves and muscles), and obesity. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 9/10/23 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #103 was cognitively intact. Review of a care plan for Resident #103 with a reference date of 8/24/23 revealed: Problem: self-care deficit related to recent hospitalization .weakness .paresthesia (feeling of tingling, numbness or pins and needles) . polio syndrome. Goal: Resident will be clean .and participate in cares to their fullest ability. Approaches: Do not rush resident .have consistent approach amongst caregivers .see resident care guide . Review of an Investigation Report dated 9/5/23 provided by the facility revealed Resident #103 reported feeling mistreated when Certified Nursing Assistant (CNA) F cared for on 9/4/24 at 4:00am. In an interview on 5/9/24 at 2:26pm Resident #103 reported on 9/4/24, CNA F came to her room at 4:00am, woke her and insisted on changing her brief. Resident #103 reported during the care, CNA F yanked on her leg that has nerve pain and it hurt so much that she almost kicked the staff member with her other leg. Resident #103 reported she heard her leg pop and began to cry due to pain and frustration. Resident #103 reported she tried to tell CNA F not to complete the care so quickly, but CNA F responded loudly and said, I know how to do my job and left the room without acknowledging that Resident #103 was upset and in pain. Resident #103 reported the experience left her feeling fearful and humiliated, and she remained emotionally uncomfortable with being a resident there throughout her stay. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	In an interview on 5/10/24 at 11:53am. Certified Nursing Assistant (CNA) F reported she recalled caring for Resident #103 on 9/4/23 at approximately 4:00am. CNA F reported she was very busy and had been told she had to assist every resident on her assignment with a brief change before the end of her shift. CNA F reported Resident #103 had a significant amount of pain and was supposed to have 2 staff members present during care. CNA F reported she asked another CNA to assist her, but the CNA refused because she was busy. CNA F reported she felt she had not time to spare so she woke Resident #103 and completed her cares alone. CNA F reported she hurried during the care and accidentally caused pain for Resident #103. CNA F reported she was aware that Resident #103 was upset after she completed her cares, but she wasn't concerned because the resident voiced pain all the time. Resident #105 Review of an Admission Record revealed Resident #105, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: encephalopathy, cognitive communication deficit, lupus (chronic disease that causes inflammation and pain), generalized anxiety disorder and unspecified intellectual disabilities. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 4/21/24 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #105 was cognitively moderately impaired. Review of a Care Plan for Resident #105 with a reference date of 11/14/23 revealed: Problem: (Resident #105's name) has the potential for vulnerability related to reduced family support or visitors, intellectual disability, and isolated behavior .Goal: (Resident #105's name) will verbalize content .will feel safe and their needs will be met. Approaches: Allow (Resident #105's name) to have control over situations when possible and safe/appropriate .convey an attitude of acceptance .encourage resident to verbalize their feelings . concerns .fears . Review of an Investigation Report dated 3/2/24, provided by the facility revealed on that date at 6:20pm, Resident #105 alleged she had been struck in the face by Resident #101. The event was unwitnessed, but staff found the 2 residents close to each other in the hallway. The report indicated Director of Nursing (FDON) C assessed Resident #105 and found no swelling, bruising, or redness. In an interview on 5/10/24 at 9:27am, agency Licensed Practical Nurse (LPN) O reported she was heard Resident #105 yelling out on 3/2/24 at approximately 6:20pm and ran to see what was happening. LPN O reported she saw Resident #105 and Resident #101 close together in the hallway and she assumed Resident #101 had run over Resident #105's foot. LPN O asked Resident #105 if her foot was run over and she said No, she hit me in the face. LPN O reported Resident #105 demonstrated what happened and described Resident #105's actions as a backhanded slap. LPN O reported Resident #105's face was red on one side, as though she'd been struck, and she was crying. LPN O then called FDON C and told her there had been a resident-to-resident physical altercation. LPN O reported Resident #101 continued to display physical aggression toward others that evening and required a staff member to stay with her at all times. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	In an interview on 5/9/24 at 2:58pm Certified Nursing Assistant (CNA) K reported she was in a nearby room when she heard Resident #105 yelling in the hallway on 3/2/24 at 6:20pm. CNA K had seen Resident #105 sitting in the hallway and Resident #101 approaching her a few minutes earlier. CNA K reported as she came up to Resident #105, she noticed her forehead was red and Resident #105 reported Resident #101 hit her in the face. When further queried, CNA K reported it was not unusual for Resident #101 to strike out at others as she passed by them in the hallway. In an interview on 5/10/24 at 3:37pm, former Director of Nursing (FDON) C reported she investigated the altercation between Resident #101 and Resident #105. FDON C reported she arrived at the facility approximately 30 minutes after LPN O called her about the incident. FDON C reported she talked with Resident #105 for quite a while but thought Resident #105 might be thinking of another time in which Resident #101 struck Resident #105. FDON C reported when asked, Resident #105 reported she was talking about the incident that happened that night. FDON C reported Resident #101 had a history of lashing out at others. When further queried about the condition of Resident #105's face, FDON C first stated there was no redness. When informed the staff who were initially on the scene reported Resident #105's forehead was reddened as though she'd been struck, FDON C reported Resident #105 did have some redness, but the redness was from her medical diagnosis of lupus. FDON C then reported she felt Resident #105 may have egged on Resident #101 with her child-like disposition, and Resident #101 reacted as a strict Momma and struck Resident #101. In an interview on 5/16/24 at 10:47am, Registered Nurse (RN) F, who cared for Resident #105 almost daily, reported Resident #105 occasionally developed a rash on her face related to her lupus and described the rash as not very noticeable with no bright redness. RN F reported Resident #105's rash occurred across the bridge of her nose and on her cheeks. Review of a physician's progress note for Resident #105 dated 3/1/24 revealed a diagnosis of butterfly rash (a flat or raised rash that occurs across the bridge of the nose and cheeks). In an interview on 5/9/24 at 2:58pm, Certified Nursing Assistant (CNA) K reported she heard Registered Nurse (RN) T tell Resident #105 she was fine and to shut up and go to sleep on several different occasions. In an interview on 5/10/24 at 4:14pm, Certified Nursing Assistant (CNA) V reported she witnessed Registered Nurse (RN) T yelling at Resident #105, turning off Resident #105's lights, pulling her curtain and closing her door while she screamed from her bed. When CNA V asked RN T what he was doing(referring to his unprofessional actions toward Resident #105), he said it was too bright in here and refused to turn the lights back on despite Resident #105's fear of the dark. In an interview on 5/10/24 at 10:19am, CNA J reported RN T's interactions with residents became hostile and when she asked him why, he told her it was bedtime, and they (the residents) should be in bed. I'm not going to engage in conversation with them at this time of night. In an interview on 5/10/24 at 10:48am, CNA L reported she told Director of Nursing (FDON) C that RN T was verbally abusive to Resident #105, but no actions were taken. In an interview on 5/10/24 at 4:21pm, CNA I reported she heard RN T say to Resident #105 Shut up and go to bed. There's nothing wrong with you. CNA I reported she heard him tell the resident to shut up on multiple occasions. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	In an interview on 5/14/24 at 2:56pm, Resident #105 stated Registered Nurse (RN) T wasn't very nice to her. When further queried, Resident #105 reported when she asked RN T for over-the-counter pain medication at night he always told her to just go to sleep. Resident #105 reported she asked for over the counter pain medication because she had a headache, but he wouldn't give her anything. Resident #105 also reported RN T would walk by her room at night and flick off her light and refuse to turn it back on even though she was afraid of the dark. Resident #105 reported RN T would not only turn off her light but then he'd close her door as well so she couldn't have light from the hallway. Resident #105 reported she felt scared and angry because of RN T's actions. Resident #106 Review of an Admission Record revealed Resident #106, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: cerebral infarction (stroke), cognitive communication deficit, aphasia (deficit in verbalizing thoughts) and weakness. Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of -2/1/24 revealed a Brief Interview for Mental Status (BIMS) score of 00/15 which indicated Resident #106 was severely cognitively impaired. Section E of the MDS revealed Resident #106 wandered daily. Section GG of the MDS revealed Resident #106 walked independently and could pick up objects off the floor independently as well. Review of a SBAR Communication Form dated 12/21/23 for Resident #106 revealed Registered Nurse (RN) F felt Resident #106 had an altered mental status because she had not slept in 24 hours, displayed continual exit seeking and was disoriented. Further review revealed the resident usually displayed exit seeking for an hour and then settled down prior to this date. Review of a nursing progress note dated 12/21/23 at 1:09am revealed: observed that resident had taken pajama top and rolled a sleeve onto her right leg so tight that the garment could not be removed and had to be cut off. Note was entered by Registered Nurse (RN) T. Review of a nursing progress note dated 12/21/23 at 5:28am revealed Resident observed sitting on the floor next to her bed folding a sheet .She has not slept all . Note was entered by RN T. Review of a social services progress note dated 12/21/23 at 11:35am revealed Nursing noted both arms are bruised . (Resident #106's name) increased exit seeking was not redirectable .staff report she is more irritable and striking out . (Resident #106) left for the emergency department . Review of a nursing progress note dated 12/22/23 at 5:58am revealed .resident hitting and scratching nurse with redirection, running down hallway attempting to open exit doors .DON and Adm (Administrator) notified of resident uncontrollable behavior . Review of an Incident Investigation Report with a reference date of 12/28/23 at 1:02pm revealed Resident #107 reported she saw a staff member dragging a resident down the hall during the night, sometime shortly before Christmas. Further review revealed the facility thought Resident #107 likely saw Resident #106 being moved down the hall by a staff member. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	In an interview on 5/16/24 at 11:57am, Certified Nursing Assistant (CNA) BB reported Resident #106 regularly lowered herself to the floor and was active throughout at least a portion of the night. CNA BB reported Resident #106 often entered other resident's room during the night an as a result, staff closed the doors to other residents' rooms. CNA BB reported she worried about Resident #106's safety because she got down on the floor frequently and RN T, who regularly cared for her at night, had threatened to stomp another resident who was crawling on the floor. CNA BB described Resident #106 as covered in bruises around the time of 12/23/23. In an interview on 5/14/24 at 3:46pm, Family Member (FM) W reported she was frequently called to the facility during the night when staff felt they could not care for Resident #106. FM W reported on 12/23/23 at approximately 1:30am, she was called because Resident #106 was exit-seeking and staff could not redirect her. FM W reported Resident #106 was sent to the hospital that night, and she met Resident #106 in the emergency department. FM W reported when she arrived at the hospital, Resident #106 was wearing a hospital gown that left both of her forearms easily viewable. FM W reported she was shocked at the condition of Resident #106's arms. FM W reported she immediately noticed Resident #106's forearms were completely covered in reddened bruises from her wrists to her elbows. FM W reported Resident #106 had multiple bruises on her lower legs as well. FM W reported the hospital staff inquired about the source of Resident #106's injuries. FM W reported she called the facility right away and asked how Resident #106 was injured and was told the resident was found at the facility with a pair of sweatpants wrapped tightly around both arms and that the wrapping was so tight the material had to be cut off. Review of a progress note written by RN T on 12/21/23 at 1:09am revealed: observed that resident had taken a pajama top and rolled a sleeve onto her R (right)leg so tight the garment .had to be cut off. No obvious injury noted . Review of a skin assessment dated [DATE] at 1:31am revealed Resident #106 had no areas of skin impairment. Review of all progress notes dated 12/23-1/24 revealed no documentation of an incident involving Resident #106 having a garment wrapped around her arms. Review of all incident/accident reports for Resident #106 with reference date of 12/23 of 12/23 1/24 revealed no documented incidences of Resident #106 sustaining an injury to her arms. In an interview on 5/16/24 at 10:45am, NHA A denied any incidents related to Resident #106 being found with her arms wrapped in a garment. Review of a skin assessment dated [DATE] at 2:19pm, completed by FDON C, revealed: bruising bilateral UEs (upper extremities), Improving, Consistent with IV's and blood draws. Review of an After Visit Summary from a local hospital for Resident #106 revealed Resident #106 had blood work done on 12/23/23 at 3:08am, 12/24/23 at 11:39am, and 12/25/23 at 6:13am. Resident #107 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of an Admission Record revealed Resident #107, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: displaced fracture of lateral condyle of right tibia, muscle weakness, unspecified fracture of the shaft of the right fibula, and depression. Review of a Minimum Data Set (MDS) assessment for Resident #107, with a reference date of 2/2/24 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #107 was cognitively intact. Review of a Care Plan for Resident #107 with a reference date of 12/21/23 revealed a Problem/Goal/Approach as follows: Problem: Resident has a dx (diagnosis) of depression .Goal: Resident will accept .assist from staff .Approach: Maintain calm environment and approach to resident .convey attitude of acceptance . Review of an Incident Investigation Report dated 1/5/24 revealed Resident #107 reported she saw another resident being moved down a hall against her will and because of the experience, Resident #107 expressed feeling uncomfortable being at the facility. In an interview on 5/8/24 at 3:39pm Resident #107 reported within days of her admission to the facility she awoke to a commotion in the hallway one night and saw a staff member hauling a resident (Resident #106) down the hall forcefully. Resident #107 reported hearing yelling coming from the hallway. Resident #107 reported staff tried to close her door and she refused to allow them to, so she saw an interaction between a staff member and a resident that appeared to too rough and felt abusive toward the resident. Resident #107 reported because of the experience, she felt anxious and fearful about the care provided at the facility. Resident #107 reported she discussed the experience with her daughter but was so scared, she opted not to discuss until she was outside of the building. In an interview on 5/14/24 at 4:20pm, Family Member (FM) AA reported Resident #107 was fearful and anxious on 12/24/24 when the resident told her about a recent event in which she saw a staff member drag a resident down the hall during the night. FM AA reported Resident #107 stated You've got to get me out of here and would not further discuss the incident until she was outside of the facility. FM AA reported she spoke with the Nursing Home Administrator regarding Resident #107's concerns and his explanation of the event Resident #107 reported did not correlate with what Resident #107 observed. When further queried about Resident #107's mentation at that time, FM AA stated her thinking was clear at that point. FM AA reported Resident #107 remained apprehensive about the care she would receive throughout the remainder of her admission. Review of a facility Abuse Prevention Program policy with a reference date of 1/24 revealed a statement: Abuse is defined as the willful infliction of injury, .intimidation, or punishment with resulting physical harm, pain or mental anguish . willful defined as used in the definition of abuse means the individual .acted deliberately, not that the individual .intended to inflict injury or harm .all staff are expected to be in control of their own behavior .behave professionally, and should .understand how to work with the nursing home population.

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F 0610 Level of Harm - Actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 This citation pertains to intake number MI00144696. Based on interview and record review, the facility failed to throughly implement the abuse policy to protect, investigate, report and prevent staff to resident abuse and bruises of unknown origin for 3 of 5 residents (Resident #101, Resident #105, and Resident #106) reviewed for abuse, resulting in ongoing staff to resident verbal and mental abuse of Residents #101 and Resident #105, escalation of the abuse to staff to resident physical abuse of Resident #101. Findings include: Resident #101 Review of an Admission Record revealed Resident #101, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia without behavioral disturbance, aphasia (deficit with verbally expressing self) delusional disorder, psychotic disorder, and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 3/16/24 revealed a Brief Interview for Mental Status (BIMS) score of 0/15 which indicated Resident #101was severely cognitively impaired. Review of a Care Plan for Resident #101 dated 11/28/23 revealed a problem/goal/approach: (Resident #101) displays .behavioral symptoms that impact her by putting her at risk for physical injury .interferes with social interactions .disrupts living environment .Goal: (Resident #101) will not cause harm to residents, staff, self . Approach: Resident placed 1:1 from after lunch until bedtime .maintain calm environment and approach to resident .when resident becomes physically abusive .report to DON (Director of Nursing) Administrator . chart in behavior log. Review of a Incident Investigation Report dated 3/5/24 revealed on 2/25/24 at 2:54pm Certified Nursing Assistant (CNA) L reported to Nursing Home Administrator (NHA) A that she witnessed Resident #101, who was seated on the floor of the hallway wearing only a gown and brief, being pulled backwards down the hall by Registered Nurse (RN) T at 1:30am. Further review of the report revealed RN T admitted he pulled Resident #101 down the hall as she sat on the floor and had done so previously as well. Resident #101 received a skin tear on her buttocks because of RN T's actions. Review of a Skin Observation Report dated 2/25/24 revealed Resident #101 had a new circular open wound on her left buttock that measured 2 centimeters in width. In an interview on 5/8/24 at 2:58pm, Certified Nursing Assistant (CNA) K reported she heard RN T say to Resident #101 Shut up no one is talking to you several times when Resident #101 spoke after hearing others talk. CNA K reported she told former Director of Nursing/current MDS Coordinator (FDON) C (now the MDs Coordinator) that Registered Nurse (RN)T was verbally abusive to residents, gave her the example of the statements she heard him say to Resident #101, and FDON C replied Oh that's just (RN T's name omitted). (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/10/24 at 10:48am, CNA L reported she witnessed another event prior to 2/25/24 in which RN T forcefully pushed Resident #101 from a standing position into a nearby wheelchair, and then lowered her onto the floor. The forceful nature of RN T's actions caused Resident #101 to yell out in fear. CNA L reported RN T appeared frustrated during his actions and it appeared abusive, so she told FDON C, but FDON C responded with she's care planned for it (being on the floor) so it's fine. Review of RN T's employee file revealed he was suspended pending an allegation of abuse on 2/25/24. Further review revealed RN T admitted he forcefully dragged Resident #101 approximately 70' on the floor during the early hours of 2/25/24 and admitted he sometimes put a gait belt around the resident's upper body and slid her down the hallway (while resident was on the floor). In an interview on 5/16/24 at 11:57am, former Certified Nursing Assistant CNA BB reported in the months leading up to the event that took place with Resident #101 on 2/25/24, CNA BB heard RN T verbally threaten to stomp on Resident #101 as she laid on the floor. When further queried about reporting the threat as abuse, CNA BB reported she did not tell FDON C because when she previously reported concerns, she was told she was lying, things were not followed up on, and she worried about retaliation. In an interview on 5/10/24 at 3:32pm, Nursing Home Administrator (NHA) A reported staff were recently re-educated about abuse reporting and were now expected to report all concerns of abuse directly to him. However, there were times when NHA A would not be accessible to staff. NHA A reported during the few times when he was unavailable, staff were educated to report abuse concerns to the manager on-call and that FDON C was the manager on-call 5/4-5/6/24.When further queried about what would happen if another manager received a staff concern of a potential situation of resident abuse but did not share the information with him, NHA A stated that's why we have a new Director of Nursing. NHA A reported he was concerned that FDON C had not always been forthcoming with information. NHA A did not indicate what would happen if FDON C, now the MDS Coordinator was the manager on duty over a weekend and something happened that required reporting. Review of a Performance Improvement Plan for DON C dated 2/1/24-3/26/24 revealed the areas for improvement were: follow up of clinical processes and concerns .accountability, ensuring items that need addressed are corrected and not just I told them . In an interview on 5/10/24 at 3:37pm, FDON C reported RN T acted like a model staff member until 2/25/24. FDON C denied receiving any staff concerns regarding RN T prior to the event on 2/25/24. When queried about potential outcomes for ongoing abuse, FDON C reported there was a risk that the level of abuse would escalate, worsening psychological impact and ultimately an increased risk of resident mortality. FDON C reported staff were expected to report concerns of abuse to the FDON, Weekend Supervisor, or NHA immediately. When further queried about why she stepped down as the Director of Nursing, FDON C reported she struggled with the responsibilities of the role and wanted to be the leader without being the boss. FDON C reported she struggled with holding staff accountable. FDON C reported in her current role (MDS Coordinator) she worked as Weekend Supervisor every 4th Saturday and was the Manager on call 5/4-5/6/24. Review of RN T's employee file revealed no corrective action related to potentially abusive behavior was taken prior to the event that occurred on 2/25/24. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/10/24 at 3:32pm, NHA A reported the facility had not investigated any allegations of staff to resident verbal abuse involving Resident #101 or any other alleged abuses prior to 2/25/24. Resident #105 Review of an Admission Record revealed Resident #105, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: encephalopathy, cognitive communication deficit, lupus (chronic disease that causes inflammation and pain), generalized anxiety disorder and unspecified intellectual disabilities. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 4/21/24 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #105 was cognitively moderately impaired. Review of a Care Plan for Resident #105 with a reference date of 11/14/23 revealed: Problem: (Resident #105's name) has the potential for vulnerability related to reduced family support or visitors, intellectual disability, and isolated behavior .Goal: (Resident #105's name) will verbalize content .will feel safe and their needs will be met. Approaches: Allow (Resident #105's name) to have control over situations when possible and safe/appropriate .convey an attitude of acceptance .encourage resident to verbalize their feelings . concerns .fears . In an interview on 5/9/24 at 2:58pm, Certified Nursing Assistant (CNA) K reported she heard Registered Nurse (RN) T tell Resident #105 she was fine and to shut up and go to sleep on several different occasions. In an interview on 5/10/24 at 4:14pm, Certified Nursing Assistant (CNA) V reported she witnessed Registered Nurse (RN) T yelling at Resident #105, turning off Resident #105's lights, pulling her curtain and closing her door while she screamed from her bed. When CNA V asked RN T what he was doing (referring to his unprofessional actions toward Resident #105), he said it was too bright in here and refused to turn the lights back on despite Resident #105's fear of the dark. In an interview on 5/9/24 at 10:48am, Certified Nursing Assistant (CNA) J reported she witnessed Registered Nurse (RN) T speaking harshly to residents, including Resident #105, and deny them food at night when they voiced hunger. CNA J said she reported RN T's behavior to FDON C and FDON C told her she would follow up with RN T, but his behavior continued. CNA J reported when asked, RN T said FDON C never spoke to him his behavior. In an interview on 5/10/24 at 10:19am, CNA J reported RN T's interactions with residents became hostile and when she asked him why, he told her it was bedtime, and they (the residents) should be in bed. I'm not going to engage in conversation with them at this time of night. In an interview on 5/10/24 at 10:48am, CNA L reported she told FDON C that RN T was verbally abusive to Resident #105, but no actions were taken. In an interview on 5/10/24 at 4:21pm, CNA I reported she heard RN T say to Resident #105, Shut up and go to bed. There's nothing wrong with you. CNA I reported she heard him tell the resident to shut up on multiple occasions. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/14/24 at 2:56pm, Resident #105 stated RN T wasn't very nice to her. When further queried, Resident #105 reported when she asked RN T for over-the-counter pain medication at night he always told her to just go to sleep. Resident #105 reported she asked for over the counter pain medication because she had a headache, but he wouldn't give her anything. Resident #105 also reported RN T would walk by her room at night and flick off her light and refuse to turn it back on even though she was afraid of the dark. Resident #105 reported RN T would not only turn off her light but then he'd close her door as well so she couldn't have light from the hallway. Resident #105 reported she felt scared and angry because of RN T's actions. In an interview on 5/10/24 at 3:32pm, NHA A reported the facility had not investigated any allegations of staff to resident verbal abuse involving Resident #105. Resident #106 Review of an Admission Record revealed Resident #106, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: cerebral infarction (stroke), cognitive communication deficit, aphasia (deficit in verbalizing thoughts) and weakness. Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 2/1/24 revealed a Brief Interview for Mental Status (BIMS) score of 00/15 which indicated Resident #106 was severely cognitively impaired. Section E of the MDS revealed Resident #106 wandered daily. Section GG of the MDS revealed Resident #106 walked independently and could pick up objects off the floor independently as well. Review of a social services progress note dated 12/21/23 at 11:35am revealed Nursing noted both arms are bruised . (Resident #106's name) increased exit seeking was not redirectable .staff report she is more irritable and striking out . (Resident #106) left for the emergency department . In an interview on 5/16/24 at 11:57am, Certified Nursing Assistant (CNA) BB reported Resident #106 regularly lowered herself to the floor and was active throughout at least a portion of the night. CNA BB reported Resident #106 often entered other resident's room during the night an as a result, staff closed the doors to other residents' rooms. CNA BB reported she worried about Resident #106's safety because she got down on the floor frequently and RN T, who regularly cared for her at night, had threatened to stomp another resident who was crawling on the floor. CNA BB described Resident #106 as covered in bruises around the time of 12/23/23. In an interview on 5/14/24 at 3:46pm, Family Member W reported Resident #106 was sent to the hospital on 12/23/23, and she met Resident #106 in the emergency department. FM W reported when she arrived at the hospital, Resident #106 was wearing a hospital gown that left both of her forearms easily viewable. FM W reported although she was very involved in Resident #106's care, she had not seen her forearms regularly because the resident preferred to wear long sleeves. FM W reported she was shocked at the condition of Resident #106's arms. FM W reported she immediately noticed Resident #106's forearms were completely covered in reddened bruises from her wrists to her elbows, practically covering her entire lower arms. FM W reported Resident #106 had multiple bruises on her lower legs as well. FM W reported the hospital staff inquired about the source of Resident #106's injuries. FM W reported she called the facility right away and asked how Resident #106 was injured and was told the resident was found at the facility with a pair of sweatpants wrapped tightly around both arms and that the wrapping was so tight the material had to be cut off. (continued on next page)

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F 0610 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/16/24 at 2:04pm, CNA K reported she recalled seeing large bruises on Resident #106's arms on 12/22/24. Review of a skin assessment dated [DATE] at 1:31am revealed Resident #106 had no areas of skin impairment. Review of all progress notes dated 12/23-1/24 revealed no documentation of an incident involving Resident #106 having a garment wrapped around her arms. Review of all incident/accident reports for Resident #106 with reference date of 12/23- 1/24 revealed no documented incidences of Resident #106 sustaining an injury to her arms or having a garment wrapped around her arms. In an interview on 5/16/24 at 10:45am, NHA A denied any incident reports related to or an awareness of an incident in which Resident #106 was found with her arms bound in a pair of sweatpants. Review of a skin assessment dated [DATE] at 2:19pm, completed by FDON C, revealed: bruising bilateral UEs (upper extremities), Improving, Consistent with IV's and blood draws. Review of an After Visit Summary from a local hospital for Resident #106 revealed Resident #106 had blood work done on 12/23/23 at 3:08am, 12/24/23 at 11:39am, and 12/25/23 at 6:13am. Review of the facility's Abuse Prevention Program policy revealed an alleged violation was defined as a situation or occurrence that is observed or reported by .staff .but has not yet been investigated and, if verified could be .mistreatment, abuse, including injuries of unknown source . Injuries of unknown source was defined as the source of the injury was not observed .could be explained by the resident .the injury is suspicious because of the extent .or the number of injuries observed at one particular point in time or the incidence of injuries over time. The policy defined indicators of abuse as .negative attitudes toward residents . verbally aggressive behavior .bossing around, intimidating . demonstrating burnout. Indicators of neglect were defined as .failure to oversee the implementation of resident care policies .failure to provide supervision and/or monitoring of the delivery of care .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - 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** 46999 This citation pertains to intake #MI00144223 Based on observation, interview, and record review the facility failed to prevent residents from insect bites and install window screen in 1 of 3 residents (Resident #108) reviewed for quality of care, resulting in Resident #108 suffering a spider bite and subsequent significant wound requiring debridement (removal of dead or infected tissue), increased pain, need for antibiotic treatment, and ongoing wound care. Findings include: Review of an Admission Record revealed Resident #108 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: cerebral infarction (stroke) aphasia (difficulty with verbal expression), depression, hemiplegia (paralysis on one side of the body), generalized anxiety disorder, and pain. Review of a Minimum Data Set (MDS) assessment for Resident #108, with a reference date of 2/28/24 revealed a Resident #108 could not complete a Brief Inventory for Mental Status due to her aphasia. Section B of the MDS revealed Resident #108 understood others and usually was able to make herself understood. Section C of the MDS revealed Resident #108 had no short or long-term memory deficits. Review of a Care Plan for Resident #108 with a reference date of 4/12/24 revealed problem/goal/approaches as follows: Problem: Wound to right outer thigh with abscess, Goal: Heal skin and prevent infection, Approaches: .Measure and assess weekly for progression of healing, provide weekly sin checks per licenses nurse . During an observation on 5/8/24 at 12:25pm, Resident #108 sat in her bed, watching television, her room window was open 3, no screen was present. During an observation on 5/8/24 at 2:55pm a brown spider crawled on the hallway floor outside resident room [ROOM NUMBER]. During an observation on 5/8/24 at 3:19pm the window in resident room [ROOM NUMBER] was open approximately 1, no screen was present. During an observation on 5/8/24 at 3:08pm, the screen in the bathroom of room [ROOM NUMBER] was noted to have a 1 hole in the screen and the window as open. During an observation on 5/8/24 at 12:52pm, 30 ants crawled on the wall near the baseboard in the facility's conference room and a dead wasp laid on the floor. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	In an interview on 5/8/24 at 2:49pm Resident #108 reported she liked to have her window open because she often got hot in her room and she liked the fresh air. Resident #108 reported she was told her wound on her right thigh was from a spider or insect bite. Resident #108 reported the wound had been very painful, and as a result she had not been able to tolerate getting up for a few weeks. Resident #108 reported the pain had improved now but the wound treatments were still painful. Resident #108 reported she wanted to have a screen in her window to reduce the likelihood of future insect bites. Resident communicated through yes/no responses, simple statements, facial expressions, and hand gestures. In an interview on 5/8/24 at 1:29pm, Family Member (FM) S reported she visited Resident #108 every other week and when she recently visited in April, Resident #108 expressed significant pain in her right leg and could not tolerate having the leg touched. FM S reported Resident #108 had never complained of pain in her right leg before. FM S reported she was told the resident had a wound from an insect bite on her leg. FM S reported she saw Resident #108's room window opened frequently when she visited and had never seen a screen in the window. In an interview on 5/9/24 at 2:58pm, Certified Nursing Assistant (CNA) K reported Resident #108 generally wanted her window opened every day and her window did not have a screen. CNA K reported other resident windows also did not have screens and she had seen several windows open with no screens in place. CNA K reported she saw ants and spiders in the building. CNA K reported Resident #108 had expressed being in pain following the tissue injury to her right leg. During an observation on 5/8/24 at 3:00pm, Maintenance Staff (MS) Q placed a screen in the window of room [ROOM NUMBER]. Review of a Skin Monitoring Shower Review dated 4/5/24 revealed Resident #108 was found to have blisters on her upper right thigh. Review of a nursing progress note for Resident #108, dated 4/10/24 at 7:32pm, revealed paged on-call physician at 7:32pm regarding wound on .posterior thigh . Review of a progress note written by Nurse Practitioner (NP) FF dated 4/11/24, revealed: Patient .has .an abscess on the right buttock which is a new wound, cellulitis with streaks of red going up her leg and wraps around her thigh .pain with touching and movement .1x1circle at the 2-3 o'clock (position) has black that is not removeable .plan: start (antibiotic name), stop (another antibiotic) .mark cellulitis and make sure it is going down . Review of a Wound Evaluation for Resident #108 dated 4/12/24 revealed: wound type: cellulitis, length 2cm, width 1.6cm, depth .1, surrounding skin redness 8cm, hardness 13cm, edema (swelling) 13cm, pain: yes. Review of a physician progress note dated 4/12/24 for Resident #108 revealed: the patient was seen for erythematous edematous (reddened, swollen) area over the right thigh. It appears the patient may have been bitten by a spider or another insect .cellulitis (bacterial skin infection) has expanded .patient is complaining of extreme pain. Review of a progress note dated 4/16/24 revealed: Resident received ultrasound to right posterior thigh, antibiotic in progress for spider bite. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a NP progress note written by NP FF for Resident #108 on 4/18/24 revealed: patient .had ID (incision and drainage) by (physician name) .it is still very painful. She has not been able to get out of bed due to the pain .change to (antibiotic name, glycopeptide antibiotic) due to(sic) I and D review. Review of a physician progress note for Resident #108, written on 4/24/24 revealed She is requesting pain medication, will increase (nerve pain medication) .Plan: increase her (nerve pain medication) to 100mg bid (twice a day) for her pain . Review of a NP progress note written by NP FF for Resident #108 on 4/25/24 revealed: She has gotten worse again as she states the pain is . causing problems which is then keeping her from being able to get up .states anything touching it is increasing the pain .she continues to have a pocket that is red, warm to touch . copious amounts of thick red/brown drainage .concern that patient is tunneling (wound is spreading deeper) wound it's self is 1cm x 1.5cm black eschar (dead tissue) .removed well over 30ml of drainage from pushing on wound, concern for tunneling . Review of a Wound Management Report dated 4/26/24 revealed Resident #108's wound measured 8cm deep with a 1.7cm x 1.6cm opening. In an interview on 5/9/24 at 10:23am, Registered Nurse (RN) F reported she regularly completed the wound care for Resident #108's wound on her right thigh. RN F reported the wound care was painful for the resident and although the resident had difficulty with verbal expression, the resident regularly said owie, owie, owie during wound care. During an observation on 5/9/24 at 10:25am, Resource Nurse/ Registered Nurse (RN) RR and RN F completed wound care to Resident #108's right posterior thigh. The wound on Resident #108's right thigh measured 1cm x 1.5cm at the opening. RN RR reported the tunneling was improving but measured approximately 5cm in depth. The wound was packed with 18 of medicated gauze. Resident #108 reported pain during the wound packing. In an interview on 5/10/24 at 12:14pm Wound Care Specialist (WCS) P reported Resident #108's wound was consistent with that of an insect bite. WCS P reported the wound was improving but had some tunneling and required wound care twice a day. In an interview on 5/10/24 at 11:29am, Maintenance Staff (MS) (Q) reported he removed all the facility's window screens in the fall of 2023 because most were broken. MS Q reported he began replacing the window screens this week and, but he did not have enough screens to cover every window yet. During an observation on 5/16/24 at 10:44am all windows were closed in the conference room, as a wasp flew around the room. Review of a pest control inspection dated 5/2/24 revealed: Resident getting bit, inspected room [ROOM NUMBER] for spiders or bedbugs, no bedbugs or spiders found. No screen in window . Review of the facility's Pest Control policy with no reference date revealed: Policy: the facility will maintain an effective pest control program to eradicate and contain common house pets .Procedure 4. Windows are screened at all times(sic) . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee, 2019, www.cdc.gov, revealed: From a public health and hygiene perspective, arthropod and vertebrate pests should be eradicated from all indoor environments, including health-care facilities. When windows need to be opened for ventilation, ensuring that screens are in good repair .can help with pest control. Insects should be kept out of all areas of the health-care facility, especially .any area where immunosuppressed patients are located.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based interview and record review, the facility failed to ensure individualized approaches were provided to 1 (Resident #101) of 3 residents reviewed for dementia care, resulting in Resident #101 experiencing avoidable stress responses to care interventions. Finding include: Review of The Unmet Needs Model, [NAME]-[NAME] and [NAME] (1995), revealed that those with Dementia develop problem behaviors from an imbalance in the interaction between life-long habits and personality, current physical and mental states and less than optimal environmental conditions. Review of an Admission Record revealed Resident #101, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia without behavioral disturbance, aphasia (deficit with verbally expressing self) delusional disorder, psychotic disorder, and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 3/16/24 revealed a Brief Interview for Mental Status (BIMS) score of 0/15 which indicated Resident #101was severely cognitively impaired. Review of a Care Plan for Resident #101 dated 11/28/23 revealed a problem/goal/approach: (Resident #101) displays .behavioral symptoms that impact her by putting her at risk for physical injury .interferes with social interactions .disrupts living environment .Goal: (Resident #101) will not cause harm to residents, staff, self . Approach: Resident placed 1:1 from after lunch until bedtime .maintain calm environment and approach to resident .when resident becomes physically abusive .report to DON (Director of Nursing) Administrator . chart in behavior log. In an interview on 5/8/24 at 1:01pm, Certified Nursing Assistant (CNA) L reported the facility had some general interventions in place to use with Resident #101, but she found they often were not effective. CNA L reported the interventions she found that work well for Resident #101 included rubbing the resident's hands, rubbing her cheek softly, and rubbing her hair. CNA L reported Resident #101 responded calmly to gentle physical touch. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235637	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Ave 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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/14/24 at 11:04am, Registered Nurse (RN) X reported Resident #101 seldom had exhibited any stress responses(behaviors) when she cared for her. RN X reported when she started working at the facility, other staff members told her that Resident #101 was a huge issue due to her behaviors, but RN X reported when she used her knowledge of dementia care, Resident #101 was content. RN X reported Resident #101 often sought interaction with her environment late in the evening, around approximately 11pm, which was not unusual for those with advanced dementia. RN X reported although Resident #101's care plan did not reflect this as an intervention, she learned that if she gave Resident #101 a portable snack that she could arrange on a clean countertop, Resident #101 was content with this activity for a few hours and ultimately would decide to go to bed in the early morning hours. RN X reported as she interacted with Resident #101 and tried different interventions, she also found that Resident #101 was very interested in certain children's books that were popular in the 1960's. RN X reported Resident #101 would listen to the book being read and enjoyed looking at the book/reading it on her own. These interventions were not reflected in Resident #101's plan of care. RN X reported she felt if the facility had implemented these interventions along with telling staff to wake Resident #101 for her medications, her behaviors/stress responses would have improved greatly. In an interview on 5/14/24 at 2:59pm, Certified Nursing Assistant (CNA) Y reported Resident #101 had some general interventions in her care plan that were supposed to help reduce the resident's stress level, but she had found that certain other interventions were much more effective. CNA Y reported Resident #101 loved ice cream and would focus on that rather than her stressors when it was offered. CNA Y reported Resident #101 also enjoyed having her head scratched lightly and would calm down when that was offered. Review of a Behavior Tracking Log dated 3/15-5/9/24 revealed interventions as follows: calm/slow approach, avoid over-stimulation, reassurance, re-approach, re-direct, diversional activity, offer toileting/snack/drink, exercise, pain relief, other. The only interventions documented during this time frame were calm approach and reassurance. Results listed for these interventions were listed as other, n/a (not applicable), and none. There was no indication that a care plan for effective interventions were discussed with staff who cared for and knew the resident. In an interview on 5/15/24 10:27am Social Services (SS) D reported all behavior documentation should be done in the electronic medical record. SS D confirmed the location of the documentation within the electronic medical record and stated, what's been done is there, but the staff haven't been documenting well. Review of a facility's Care for Residents with Dementia policy with a reference date of 1/24 revealed: Purpose: to ensure that the individual needs of the resident with dementia are met and that the staff have the knowledge to provide the appropriate care and services .potential interventions: It's important to have an accurate assessment .to plan individualized interventions .ensure that you are providing a patient centered environment .