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	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Avenue 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to protect resident privacy during personal care for 1 (Resident #109) of 10 residents reviewed for privacy/dignity, resulting in the potential for feelings of embarrassment. Findings include: Review of an admission Record revealed Resident #109 was a male with pertinent diagnoses which included cellulitis of right lower limb, edema, changes in skin texture to BLE (bilateral lower extremities), cellulitis of left lower limb, and erythematous condition (red or abnormally reddened that appears red due to inflammation, infection, and other irritation). Review of current Care Plan for Resident #109, revised on 3/21/25, revealed the focus, .Resident has a bilateral lower extremity chronic venous ulcers with potential for infection and discomfort to the area . with the intervention .Administer analgesic as ordered prior to wound care, dressing changs or debridement, avoid friction and shearing during transfers or repositioning, conduct a systemic skin inspection weekly and PRN (as needed). CNA to observe skin integrity during daily cares . Review of Order dated 8/12/25 for Resident #109, revealed, .Unna Boot Zinc Calamine bandage; 3% -3%-4x10 yard; amt: one bandage; topical; Special instructions: apply one bandage to bilateral ankles and feet every other day unit area is healed, Once a day Every Other Day 09:00 AM . (Unna boot - zinc oxide impregnated compression bandage used to treat leg conditions like swelling and venous ulcers). During an observation on 09/15/25 at 09:19 AM, Resident #109 was observed in the hallway in his wheelchair, his bilateral lower extremities was covered with dry, flaky skin which was peeling off and he was instructed by Registered Nurse (RN) L his legs needed to wrapped and he was taken to the doorway of the nurse's station where RN L began to perform wound dressing. She had pulled a chair to the doorway and had began to wrap his lower leg with the dressing. Director of Nursing (DON B observed her performing the wound dressing in the doorway and asked her to take Resident #109 to his room, RN L reported his room was too small for her to dress his lower legs but she instructed Resident #109 to self-propel to his room so she could perform the wound dressing. Resident #109 had just returned from the whirlpool where he went to provide moisture to his lower legs. This writer observed Resident #109 seated just inside of his doorway with RN L kneeling on the floor in the hallway while she performed the wound dressing. There were no chucks on the floor under Resident #109's feet. In an interview on 09/17/25 at 1:14 PM, Assistant Director of Nursing (ADON) C reported Resident #109 would go to the whirlpool, when finished complete wound dressing, and on his bed and on the floor next to his bed would be lined with chucks, so if there was skin and blood it would be on the chucks. Observed his feet had blood between his toes and the tops of his foot by the toes, the dressing had spots of pink, fresh blood weeping through dressing. In an interview on 09/17/25 at 2:57 PM, Director of Nursing (DON) B reported RN L should not have been performing wound dressing at the nurse's station to maintain Resident #109's dignity. She reported couldn't believe she had started to perform the wound dressing at the nurse's station within 15 minutes of this writer observing the hallways.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235637	A. Building B. Wing	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Avenue 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. (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	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Avenue 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure access to a call light in 4 of 10 sampled residents (Resident #104, R#102, R#105, and R#106) reviewed for call light placement, resulting in the inability to call for assistance and the potential for unmet care needs.Findings include: Resident #104Review of an admission Record revealed Resident #104 was a female with pertinent diagnoses which included Alzheimer's disease, diabetes, fracture of lower end of left femur, fractur of lower end of right femur, overactive bladder, and dementia. Review of current Care Plan for Resident #104, revised on 1/24/25, revealed the focus, .At risk for falls and subsequent injury related to fx (fracture) of fall w/ bilat femur fx prior to admission, incontinence, DM II (diabetes), vascular dementia, Alzheimer's, dependence in ADLs and transfers. with the intervention .Recline Broda chair when resident is unattended.Call light to be in reach. Instruct and remind to use call light to ask for assistance. During an observation on 09/15/25 at 1:44 PM, Resident #104 was observed in her room, broda not reclined, and was sliding down in her chair, and she was attempting to get up out of the chair. This writer observed Resident #104's call light hung over the back of the headboard to her bed and her water was on the nightstand. Both clearly out of Resident #104's reach. Resident #104 had been observed in her room since after lunch. This writer attempted to press the call light to call for assistance for Resident #104. This writer checked the door and Resident #104's call light was not illuminated in the hallway. Certified Nursing Assistant (CNA) U was observed down at the nurse's station, and she was hailed to come and assist as no other staff were in the hallway. Resident #104's room was located at the end of the hallway by the emergency exit door out the side of the building. CNA U came to Resident #104's room and was queried if Resident #104 should have her call light in reach. CNA U reported she doesn't use it. Queried if her water should be by her, CNA U reported Yes, her water should be in reach. CNA U reported Resident #104 was able to eat and drink independently. CNA U pressed the call light, and it did not illuminate in the hallway above the door. This writer went to the nurse's station to determine if it was beeping at the nurse's station as no one was coming to assist. Assistant Director of Nursing (ADON) C reported the call light was beeping but the light was not illuminated on the board. [NAME] indicated the beeping was the call light, went to the board and it was not illuminated. Maintenance Director (MD) E was informed the call light in Resident #104's room was not working. MD E went to the call light board and the room as not illuminating on the board. During an observation on 09/15/25 at 2:07 PM, Resident #104 had her call light draped over her right side and she had he rolling bedside table next to her bed with her water mug on it. In an interview on 09/15/25 at 3:19 PM, MD E reported he replaced the bulb and it blew multiple bulbs and now the panel won't light up. MD E reported he took out the call light, tested it and it had looked as if someone had yanked the call light out of the wall socks so he placed a splitter on the other call light so both residents in the room had operating call lights. MD E reported the all the call lights were working, just the lights on the board. MD E reported the system had to be 20-[AGE] years old and the plastic shattered when he pressed it. MD E reported he had someone coming to look at the system. Resident #102: Review of an admission Record revealed Resident #102 was a male with pertinent diagnoses which included displaced midcervical fracture of right femur (break in the middle part of the neck of the femur, bone fragments, and are no longer aligned), adult failure to thrive, intracapsular fracture of femur (break of femoral neck which is located within the hip joint's capsule), anxiety, dysphagia (difficulty swallowing foods and liquids), and stroke. Review of current Care Plan for Resident #102, revised on 12/2/24, revealed the focus, .At risk for falls and subsequent injury related to dementia with cognitive decline over the last year, hx (history) of CVA (stroke), insomnia, CKD 3 (Chronic kidney disease, stage 3), urinary frequency r/t (related to) BPH. Non-compliant with medical care. Resident has poor cognition and weakness. Fall with hip fx (fracture) and surgical repair July 2025. with the intervention .Parameter mattress.Enabler bars to Right side of bed.Call light to be in reach. (Note: Fall mattress was not developed as an intervention to Resident #102's care plan).During an observation on 09/15/25 at 2:04 PM, Resident #102 was lying in his bed still, mattress on the floor next to his bed, he had not drunk any of his orange juice from this morning, his water was out of reach it was placed at the other end of the rolling bedside table which was placed against the wall/window area. This writer did not observe resident's call light cord or call light button. During an observation on 09/15/25 at 2:12 PM, Resident #102 was observed in his room and he was leaning out of bed, he had his left hand on the mattress which was on the floor and he had a cup of red juice in his right hand. Resident #102 then took his left hand and

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	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Avenue 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 - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Avenue 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 - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to intake: 2618457 and 2618789Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from staff to resident sexual abuse for 1 resident (Resident #108) reviewed for abuse, resulting in Resident #108 feeling concerned for physical safety enough to leave shortly after admission. Findings include: Review of Incident Summary submitted on 9/11/25, revealed, .Incident Summary: On 9/11/25, administrator received a call from staff of a sexual abuse allegation reported to them from resident (Resident #108), a newly admitted resident. Admin immediately went to the facility and made contact with the resident via phone, as resident has already left the building with her son prior to administrator's arrival. (Resident #108) reported that (LPN J), LPN, had performed a physical assessment of her, and during this assessment, when he got to my boobs, he pinched my nipples and rubbed them between his fingers. I don't think that is proper. He made me feel really uncomfortable. Resident states she is ok now and is grateful that administrator called her and followed up with investigation. Resident had contacted her son, (Family Member (FM) AA, after the alleged incident. (FM AA) arrived at the facility prior to administrators arrival and took (Resident #108) home, not signing any paperwork. Nurse (LPN J) was immediately suspended pending investigation. Administrator spoke to the son, (FM AA), who stated he had received this phone call from his mother regarding the allegation and took her out of there as quick as I could. (Local) County Police were notified of the incident. MD (Medical Director) made aware. No other residents had any concerns of this nurse at this time. DON (Director of Nursing) notified, RDO (Regional Director of Operations) notified. Investigation to follow. Resident #108: Review of an admission Record revealed Resident #108 was a female with pertinent diagnoses which included diabetes, chronic pain, congestive heart failure, dependency on oxygen, anemia, anxiety and kidney disease. Review of Return to Hospital Risk Assessment dated 9/11/25 at 5:20 PM, revealed, .Medical conditions: CHF, COPD, Diabetes, Stroke.Review of Fall Risk Assessment dated 9/11/25 dated 5:18 PM, revealed, .Medical Conditions: Cognitive Impairments: No. Review of Braden Scale For Prediction of Pressure Sore Risk dated 9/11/25 at 5:10 PM, revealed, .Sensory Perception: No Impairment - Responds to verbal commands. No sensory deficit limiting ability to feel or voice discomfort/pain. Review of Skin Assessment dated 9/11/25 at 5:09 PM, revealed, .Skin conditions: No areas of skin impairment. In an interview on 09/17/25 at 08:25 AM, Resident #108 reported the nurse came to her room to check me over and he pulled up my top, took my nipples and rubbed them between his two fingers, just my nipples, and when he was finished her walked out and never said a word to me. Resident #108 stated That was not acceptable and she couldn't stay there anymore. Resident #108 reported she contacted her son to come and get her. When queried if she had any bruises on her abdomen area, Resident #108 reported she had received blood thinner shots in the hospital but they were not on my boobs. Resident #108 reported LPN J was not interested in my abdomen area. Resident #108 reported she hailed down another staff member; to please help her, she explained what had happened to her by the nurse and wanted to report her concern. Resident #108 reported she was legally blind but was able to see brighter colors and shapes. Resident #108 stated, she knew if this had happened to her, it happened to others. In an interview on 09/17/25 at 08:11 AM, Family Member (FM) AA reported his mother (Resident #108) called him, reported to him what had happened to her by the nurse, and she wanted me to come and get her. FM AA reported Resident #108 felt very uncomfortable staying there and said there was no reason the nurse would need to touch her breasts especially her nipples like that. FM AA reported he was very upset at what happened to his mother. In an interview on 09/17/25 at 09:27 AM, Licensed Practical Nurse (LPN) J reported the prior nurse did most of the assessments, but the Critical admission assessment was left to finish. LPN J reported at approximately 7:00 PM, he went to Resident #108's room to complete the Critical admission assessment. Observed Resident #108's torso, noticed bruising and left the room to obtain a measuring tape from the nurse's station. LPN J reported Resident #108 accused him of touching her breasts inappropriately and he denied the allegation. LPN J reported he did not touch her breasts and did not see Resident #108's nipples. LPN J reported he was confronted by Resident #108's son and he didn't know what he was accusing him of. LPN J reported Resident #108 had informed his co-worker of her concern with him , and LPN J said to the co-worker, don't try to add your take on it. LPN J stated He did not even blame the lady, he blamed his co-worker who did the report. In an interview on 09/17/25 at 09:42 AM, Assistant Director of Nursing (ADON) C reported he had completed the initial assessments on Resident #108 needed at admission. ADON C reported for the Critical admission Assessment he only needed the last set of vitals

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	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Avenue 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Avenue 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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to 1287744Based on interview and record review, the facility failed to prevent the misappropriation of narcotic pain medication in 1 of 10 residents (Resident #103) reviewed for misappropriation of property, resulting in the theft of narcotic medications and the potential for delayed pain treatment.Findings include: Resident #103: Review of an admission Record revealed Resident #103 was a male with pertinent diagnoses which included MS (multiple sclerosis), polyneuropathy (multiple sites of nerve damage), heart failure, end stage renal disease, and osteoarthritis (flexible tissue at the end of bones wears down). Review of current Care Plan for Resident #103, revised on 1/28/25, revealed the focus, .Resident has potential/actual pain r/t (related to) MS, hx (history) of falls, ESRD on dialysis, CHF (congestive heart failure), HTN (high blood pressure), Anemia, OA (Osteoarthritis). with the intervention .Administer pain medications as ordered.Review of Order dated 4/26/25 for Resident #103, revealed, .Percocet (oxycodone-acetaminophen) - Schedule II tablet; 7.5-325 mg; amt: one table; oral.Every 6 hours - PRN (as needed). In an interview on 09/16/25 at 2:44 PM, Licensed Practical Nurse (LPN) F reported Resident #103 requested a pain pill. LPN F reported she reviewed his medical record and the narcotic sign out sheet to see if he was able to receive a dose of Percocet. Upon review of the narcotic sheet, it was documented he had received a dose a 8:00 PM so she went to tell Resident #103 he was not able to receive a pain medication just yet as it had not been 6 hours since his last dose. LPN F reported Resident #103 indicated he had not received Percocet at 8:00 PM. Resident #103 was alert and oriented, he knows his medications and he would remember if he had received pain medication at 8:00 PM. LPN F reported when she and LPN I had counted the cart all the medications dispensed matched what was in the cart. LPN F reported after further review of the narcotic sheet, LPN I had signed out two doses of PRN (as needed) medication for Resident #103 for that day, 1400 (2:00 PM) and 2000 (8:00 PM). LPN F reported Resident #103 had been at dialysis most of the day and he did not receive the 2:00 PM dosage as indicated on the narcotic sheet and Resident #103 reported he did not receive the 8:00 PM dosage. LPN F reported she informed administration of the concern with medication misappropriation. In an interview on 09/17/25 at 2:12 PM, LPN I reported she was an agency nurse and there was a lot going on that day, it was her first day there and she was by herself from 2:00 PM until the next nurse came on. LPN I reported she had patients coming back from dialysis, an admission, and approximately 40 patients to take care of. LPN I reported when narcotic medications were given to a resident the nurse would verify the order, make a notation on the narcotic count sheet, dispense to the correct resident and then document in the electronic medical record. LPN I reported the main thing was sign it out on the sheet when took it out. LPN I reported the transfer and count off for the narcotics was good, nothing was wrong otherwise the oncoming nurse wouldn't have taken the keys. LPN I' reported Resident #103 reported he did not get his pain medication and LPN I reported she had given him the pain medication when she did his dressing change. LPN I denied the misappropriation of medication. In an interview on 09/17/25 at 10:19 AM, Resident #103 reported he did remember the incident and reported he was upset that she documented she gave him the medication when she didn't give it to him. Resident #103 reported he had a headache and had been at dialysis all day, when he went to dialysis it really wiped him out. Resident #103 reported it had been a long day and he was in pain. Resident #103 when LPN F told me a pain medication had been dispensed to me at 8:00 PM, he reported he told her if he had one earlier his pain wouldn't have been like it was. Review of Statement of interview between DON (Director of Nursing B) and (Resident #103) revealed, .At 0645 am I, (Name of Director of Nursing (DON) B), RN DON at (Facility), spoke with (Resident #103) related to his pain medication record from 6/25/26.(Resident #103) did state yes when asked if he received his Oxycodone-Acet 7.5mg-325mg at 0800.(Resident #103) goes to dialysis from 940 to approximately 430-500pm on M, W, Fri. He was not in the building at 1400.(Resident #103) said no, I did not get any pain medication at 8o'clock I fell asleep around 7pm with a migraine and did not wake up until 9 or 10pm and then I asked (LPN F) (nurse on duty 6p-6a) for a pain pill. I only got 2 yesterday.This is a true statement of the conversation between (DON B) DON and myself. Review of Medication Administration Record (MAR) dated 6/25/25 -6/26/26 revealed, .Percocet (oxycodone-acetaminophen) - Schedule II tablet; 7.5-325 mg; Amount to administer: one tablet; oral.Wednesday, 6/25/25 at 10:36 PM.(LPN F), LPN).PRN reason: Pain.PRN Result: E (Effective).Review of MAR dated 6/21/25 - 6/25/25 revealed, 6/22/25: (LPN F) at 1:35 AM, Pain, E 6/23/35: (LPN BB) at 8:16 AM, Pain, E (LPN F) at 10:36 PM, Pain, E, (LPN BB), LPN (LPN

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	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Avenue 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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update and revise the person-centered care plan in a timely manner with appropriate interventions for the prevention of undefined care concerns for 1 of 10 residents (Resident #102) reviewed for care plans, resulting in the potential for physical, mental, and psychosocial unmet care needs and harm. Findings include: Resident #102: Review of an admission Record revealed Resident #102 was a male with pertinent diagnoses which included displaced midcervical fracture of right femur (break in the middle part of the neck of the femur, bone fragments, and are no longer aligned), adult failure to thrive, intracapsular fracture of femur (break of femoral neck which is located within the hip joint's capsule), anxiety, dysphagia (difficulty swallowing foods and liquids), and stroke. Review of current Care Plan for Resident #102, revised on 12/2/24, revealed the focus, .At risk for falls and subsequent injury related to dementia with cognitive decline over the last year, hx (history) of CVA (stroke), insomnia, CKD 3 (Chronic kidney disease, stage 3), urinary frequency r/t (related to) BPH. Non-compliant with medical care. Resident has poor cognition and weakness. Fall with hip fx (fracture) and surgical repair July 2025. with the intervention .Parameter mattress.Enabler bars to Right side of bed.Call light to be in reach. (Note: Fall mattress was not developed as an intervention to Resident #102's care plan). Review of Skilled Note dated 8/12/25 at 10:43 AM, .Floor mattress in place . During an observation on 09/16/25 at 7:58 AM, Resident #102 was observed in bed on his left side, he had his call light clipped to the bedding at the head of the side of the bed in the same position as yesterday. The fall mattress was up on its side leaning against his wheelchair. Resident #102 reported he did not get up for breakfast this morning. His wheelchair was up against his dresser which was on the opposite wall by the closet/bathroom. In an interview on 09/16/2025 at 8:09 AM, Director of Nursing (DON) reported the fall mattress should have been by the side of the bed for Resident #102 as he had fallen out of bed before and he had a hip fracture from that fall. back on the right side as the extra pillows were for positioning. In an interview on 09/17/25 at 1:23 PM, DON B reported the care plans were updated by all the clinical staff during morning meeting. DON B reported therapy had a communication binder where they would place information there for changes in residents' transfer status or how the resident transferred. DON B reported when the care plan was updated this was communicated to the staff verbally when the changed happened. Review of Fundamentals of Nursing ([NAME] and [NAME]) 8th edition revealed, If the patient's status has changed and the nursing diagnosis and related nursing interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care. Review and modification enable you to provide timely nursing interventions to best meet the patient's needs .It is necessary to revise related factors and the patient's goals, outcomes, and priorities. Date any revisions. Revise specific interventions that correspond to the new nursing diagnoses and goals. Revisions need to reflect the patient's present status. [NAME], P.A., [NAME], A. G., Stockert, P.A., & Hall, A. (2014). Fundamentals of Nursing (8th ed.). St. Louis: Mosby, p. 257-258.

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	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Avenue 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. (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	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Avenue 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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure clean and sanitary shared medical equipment, wheelchair cleaning for 1 (Resident #106) of 10 residents, resulting in the potential for cross contamination, infections, and bacterial harborage. Findings include: Resident #106: During an observation on 09/15/25 at 2:33 PM, Resident #106 was observed seated in a scoot/broda chair next to the side of his bed. His chair was visibly dirty, the pad under his bottom had dried liquid material on it, tan, white, brown in color. The arm rest on the right side on the outside had smeared white material, dirt and debris built up on it. The floor in his room was dirty and had splatters on it with dark brown material in it. During an observation on 09/16/2025 at 8:16 AM, Resident #106 was observed lying in bed, his chair had dried food material on the arms rests, on the front down the front of it, and the sides of the seat. His room had chocolate chip cookie pieces on the floor and dirt/debris. The pads on his chair were really dirty, ingrained dirt and body oils in the padding. Resident #106's scoot/broda chair was soiled for the duration of this writer's observations during the survey, 09/15/25 -09/17/25. During an observation on 09/15/25 at 11:23 AM, this writer observed the shower room, non-slip strips coming up from the floor, tile missing on the wall cracked tile at the bottom of the corner, two inflated pillow head rest on the floor and yellow basin placed in the middle of it. The floor had dirt and debris on it, shower chair in the hallway, it had in the visibly dried brown material dried on it, floor under the shower bench had dirt and debris on it, the floor in the room was wet and had dirt and debris on the floor. During an observation on 09/16/2025 at 08:21 AM, The shower chair was still in the hallway outside of room [ROOM NUMBER] and it was still encrusted with dried brown material, white material coated on the seat and white/brown material on the lower part of the backrest of the shower chair. During an observation on 09/16/25 at 08:33 AM, The sit to stand in the hallway across from room [ROOM NUMBER] had dirt and debris on the footrest and the based where feet can go as well. The knee plate had dried material at the bottom of the knee plate on the outer bent edges. The top middle and the very top of the knee plate. During an observation on 09/17/25 at 10:36 AM, The shower chair was still in the hallway outside of room [ROOM NUMBER] and it was still encrusted with dried brown material, white material coated on the seat and white/brown material on the lower part of the backrest of the shower chair. In an interview on 09/17/25 at 11:00 M, CNA T reported she would let maintenance know that we are done with the shower and do the floors for use. CNA T reported the CNAs were to clean the shower, shower chairs using the purple sanitizing wipes and remove soiled linens. CNA T reported the third shift CNAs were the ones responsible for cleaning the chairs of the residents on that shift. She indicated there was a schedule for what rooms for each day. In an interview on 09/17/25 at 12:26 PM, Housekeeper V reported the housekeepers do go in the shower room and clean in there, the CNAs were to spray it down, not leave items used to with the resident in the shower room such as wash cloths towels and definitely not take a stack of clean towels in there and leave them. Housekeeper V reported it was usually the CNA who spray down the shower chairs but she was unsure who cleaned them if they were encrusted with dried material. In an interview on 09/17/25 at 1:02 PM, Maintenance Director (MD) E reported it was the CNAs job to clean the shower chairs, but anyone who noticed the chair was dirty should clean it. For the shower rooms, the staff should clean the shower room, gathering everything possible, towels, etc., the housekeeper would mop, spray disinfectant and take out the trash. MD E reported there was not a checklist for the housekeeper's responsibilities for the work required of the housekeeping staff for shower rooms. In an interview on 09/17/25 at 3:30 PM, Director of Nursing (DON) B reported Certified Nursing Assistants (CNAs) were responsible for spraying down with sanitizing cleaner on used areas in the shower room and dispose of all used soiled linen prior to exiting, housekeepers would clean the floor. DON B reported the shower chairs were sprayed down after each use and if the chair was soiled with bodily fluids it should be cleaned up right away. DON B reported all shared equipment should be cleaned after each use and if it is visibly soiled. DON B reported there was a cleaning schedule for third shift CNAs to clean the resident's wheelchairs/Broda chairs.