

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER Plainwell Pines Nursing and Rehabilitation Communi		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2677662Based on interview, and record review, the facility failed to provide adequate monitoring and supervision to prevent elopement and respond appropriately to door alarms and Wanderguard (an alert bracelet that triggers an alarm near specific exits in the facility) alarms to ensure resident safety in 2 residents (Resident #101 and #104) of 2 residents reviewed for elopement/supervision, resulting in an Immediate Jeopardy when on 11/23/25 at approximately 6:00 PM, Resident #101 who was an elopement risk, exited the facility, unbeknown to facility staff, and was found by another resident, standing outside of the facility at an emergency exit door and the potential for Resident #104 to elope due to unknown Wanderguard functionality. This deficient practice placed all residents, identified as at risk for elopement, at risk for serious harm, injury, and/or death. Findings include:The facility failed to provide adequate supervision to prevent elopement for Resident #101, who was an elopement risk with a known history of following staff to exit doors, and respond appropriately to an alarming exit door to ensure resident safety. Resident #101 was found by another resident approximately 10 minutes later, located approximately 70 feet from where she had exited the building, standing outside of the facility, pulling on an exit door in an attempt to reenter the facility. The Immediate Jeopardy began on 11/23/25 when the facility failed to supervise Resident #101 and she eloped from the facility at approximately 6:00 PM. The Nursing Home Administrator (NHA) was notified of the Immediate Jeopardy on 12/16/25 at 2:20 PM. The surveyor confirmed by observation, interview, and record review that the Immediate Jeopardy was removed on 12/17/25, but noncompliance remains at a scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy due to sustained compliance has not been verified by the State Agency.Resident #101Review of a Face Sheet revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 8/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #101 had severe cognitive impairment. Review of Resident #101's Elopement Risk Assessment dated 8/23/25 indicated the resident was at risk for elopement due to the resident being physically capable of walking out of the facility, having had a history of wandering or elopement, had verbalized the desire to leave the facility or return home, and the resident searches for spouse or family. Review of Resident #101's Fall Risk Assessment dated 8/23/25 indicated the resident was at high risk for falls due to cognitive impairments, incontinence, foot problems and medications that can cause low blood pressure. Review of Resident #101's Behavioral Care Plan dated 4/8/25 revealed, At risk for elopement from the facility r/t (related to) exit seeking behavior and/or verbalizations of wanting to leave. Interventions: .wears a wander guard, function and placement checked every shift.Review of Resident #101's Elopement Risk Biographical Data located in the elopement binder at the nurse's station revealed, a photograph of the resident, a list of physical characteristics, responsible party contact information, and Behavior Patterns: confused, seeking exit to find her car and significant other.Review of the Facility Reported Incident (FRI) for Resident #101 revealed, On 11/23/25, Administrator was notified of (Resident #101) having been outside unattended and unsupervised, and brought back into the facility. Per staff, resident was last seen indoors approximately 10 minutes prior to this event. Resident was dressed in sweat pants, a plaid button up shirt and a cardigan sweater with furry boots on her feet. Temperature outside was 43 degrees Fahrenheit at the time. Wanderguard was in place and functioning properly, verified by maintenance director upon inspection. Physician, DON (Director of Nursing), and brother of the resident was notified. Vital signs obtained and within normal limits. Head to toe assessment and pain assessment was completed and no areas of concerns noted at this time. Resident has a BIMS score of 3. Resident was pleasant and no acute distress was noted. During investigation of elopement on 11/23/25, the facility identified staff did not respond to the door alarm in a timely manner to reduce risk of elopement for a resident identified as an elopement risk.In an interview on 12/16/25 at 8:25 AM, NHA A reported that on 11/23/25 Resident #101 was believed to have exited the facility unsupervised through the employee entrance door, in an attempt to follow Certified Nursing Assistant (CNA) C, who had left the facility for break at approximately 6:00 PM. An agency nurse, Registered Nurse-Agency (RN-A) J was approached by another resident (at an unknown time), who reported that Resident #101 was seen outside of the facility at the end of west hall trying to open the emergency exit door. At that time RN-A J brought the resident inside. NHA A reported that CNA C have driven to a nearby</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2648515Based on observation, interview and record review, the facility failed to ensure that medication records were in order and that an account of all controlled drugs was maintained and accurately reconciled for 2 residents (Resident #102 and #107) of 4 residents reviewed for the administration of controlled medications, resulting in the potential for ineffective management of pain and the potential for diversion of controlled drugs. Findings include:Resident #102 Review of a Face Sheet revealed Resident #102 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: chronic pain. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 10/6/25 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #102 was cognitively intact. During an observation and interview on 12/16/25 at 3:13 PM in Resident #102's room, the resident reported that she takes Tylenol and Oxycodone (controlled substance pain reliever) because she had a lot of pain in her neck, shoulders, legs, and back. Resident #102 reported that the nurse brings her medicine regularly and she does not have to ask for it. Resident #102 reported that it seemed like the night nurse at times skipped her medications or told her that it was too close to her daytime dose. Review of a Facility Reported Incident (FRI) revealed, On 10/3/25, The Director of Nursing (DON) notified the administrator that there was a discrepancy with a resident's narcotic count. (Licensed Practical nurse (LPN) M) worked the 6p-6a shift on 10/2/25. She counted off on 10/3/25 at approximately 6:00am with oncoming nurse (Registered Nurse (RN) D). No discrepancies were noted in the shift-to-shift narcotic count at this time. During AM med pass, as (RN D) was preparing (Resident #102's) morning medications, she noticed that the Oxycodone IR (immediate release) 5 mg (milligrams) count was not correct. She then Notified the DON. The DON searched the medication cart and the missing Oxycodone was not discovered. The DON and (RN D) re-counted the medication cart and no other discrepancies were noted. The DON and (LPN M) counted the other medication cart and no discrepancies were noted. Both Nurses were suspended pending investigation. MD (medical director) made aware. (Resident #102) was assessed for pain and no concerns were noted. Her scheduled pain medication was administered per MD order. (RN D) who has been employed with (facility) since 9/5/2025 as a floor staff nurse. The date of this incident was her first day on the floor working by herself, as she had just completed her job shadow training. (RN D) was the day shift nurse working on Med Cart 1, assuming responsibility for the cart on this day shift. (LPN M) was the off-going nurse, who was still in the facility, awaiting her relief for Med Cart 2. The shift change narcotic count between nurses was completed and signed off as accurate on med cart 1. (RN D) went to administer a scheduled Oxycodone to (Resident #102), when she noted only 19 pills on the narc card, instead of the 20 noted on the proof of use sheet. (RN D) reported this concern to the DON. A search of the cart was performed, and no pill was discovered. All other pills were recounted, and no other discrepancies were noted. (LPN M) then counted Med Cart 2 with the DON and no discrepancies were noted on Med Cart 2. Per policy, both employees were suspended pending investigation and asked to provide a urine specimen for testing. (RN D) was compliant and provided a specimen without incident and her drug screen was negative. She then left the facility, awaiting further instruction. (LPN M) refused to provide the specimen, leaving the facility, and was terminated, per policy. (LPN M) did return to the facility later in the afternoon, provided a specimen and her drug screen was negative. Conclusion: Based on interviews and investigation, this facility concludes this allegation of misappropriation is inconclusive. Although the pill was not found, it is not clear what may have happened to it, or that misappropriation did occur. The resident did not suffer any ill effects of the event. Education has been provided to (RN D), and initiated for all staff surrounding the narcotic handling process. Review of a statement by DON B dated 10/3/25 revealed, .At 7:40 AM, (RN D) was removing Oxycodone IR (immediate release) 5 mg for (Resident #102), signed proof of use sheet and noticed that the proof of use sheet had the number 20 in the QTY REM (quantity remains) column. The blister pack had 19 pills remaining. At 7:50 AM, RN D notified (DON B) that the number of pills did not match the number written on the proof of use sheet.(Director of Nursing (DON) B) made copies of the proof of use sheet and ran a report, medication administration (MAR) to match the signatures on the sheet with the initials in the administration record. There were 2 times that an agency nurse initiated in the MAR that was given but it was not signed out on the proof of use sheet.Review of the facility Narcotic (controlled substance) Action Plan (AP) dated 10/2/25 (sic) revealed Concern leading to AP development: Facility not adhering to Narcotic</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>(continued on next page)</p>

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Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 8/29/25 revealed a Brief Interview for Mental Status (BIMS) score of 3, out of a total possible score of 15, which indicated Resident #101 had severe cognitive impairment. Review of the Facility Reported Incident (FRI) for Resident #101 revealed, On 11/23/25, Administrator was notified of (Resident #101) having been outside unattended and unsupervised, and brought back into the facility. Per staff, resident was last seen indoors approximately 10 minutes prior to this event. Resident was dressed in sweat pants, a plaid button up shirt and a cardigan sweater with furry boots on her feet. Temperature outside was 43 degrees Fahrenheit at the time. Wanderguard (a bracelet device that triggers an alarm when in the proximity of an exit) was in place and functioning properly, verified by maintenance director upon inspection. Physician, DON (Director of Nursing), and brother of the resident was notified. Vital signs obtained and within normal limits. Head to toe assessment and pain assessment was completed and no areas of concerns noted at this time. Resident has a BIMS score of 3. Resident was pleasant and no acute distress was noted. During investigation of elopement on 11/23/25, the facility identified staff did not respond to the door alarm in a timely manner to reduce risk of elopement for a resident identified as an elopement risk. In an interview on 12/16/25 at 8:25 AM, NHA A reported that on 11/23/25 Resident #101 was believed to have exited the facility unsupervised through the employee entrance door, in an attempt to follow Certified Nursing Assistant (CNA) C, who had left the facility for break at approximately 6:00 PM. An agency nurse, Registered Nurse-Agency (RN-A) J was approached by another resident (at an unknown time), who reported that Resident #101 was seen outside of the facility at the end of west hall trying to open the emergency exit door. At that time RN-A J brought the resident inside. NHA A reported that CNA C have driven to a nearby store and returned to the facility reportedly 10 minutes later to find multiple alarms sounding, but Resident #101 was already back inside of the building at that time. NHA A reported that RN-A J stated that he had heard the alarms but had expected the alarms due to shift change as staff were entering the building through alarmed doors and therefore did not respond to them. In an interview on 12/16/25 at 11:17 PM, CNA C reported that on 11/23/25 Resident #101 had been following her around the facility just prior to her leaving for break at approximately 6:00 PM. CNA C reported that she exited the west employee entrance door and drove to a nearby store (6 minutes one way from the facility) and when she returned found multiple alarms going off in the facility, including the door and Wanderguard alarm at the west employee entrance. CNA C reported that she entered the codes to shut each alarm off, but there were still alarms sounding at other doors. CNA C reported that RN-A J, Licensed Practical Nurse-Agency (LPN-A) L and Resident #101 were all at the nurse's station when she returned. CNA C was concerned because RN-A J was not in agreement that the incident should be treated as an elopement, therefore she called DON B for further instructions. CNA C reported that she had been working in the facility for years, knew the door alarm systems, but was not sure what to do in the moment, or that there was an elopement binder at the nurse's station for reference. When CNA C spoke to DON B, she was instructed to complete a head count to ensure all residents were safe. In an interview on 12/16/25 at 11:39 AM, RN-A J reported that on 11/23/25 around 6:00 PM (shift change) he was on east hall when he heard the door alarm for the first time. RN-A J reported that at that same time LPN-A L had entered the building through the front lobby door and set the alarm off. RN-A J reported that he did not go to the door because he was not familiar with the facility alarm system and thought someone else would turn it off. Then while trying to report off to LPN-A L, RN-A J said that he could not concentrate because there were so many alarms and stated, it was excessively over stimulating. RN-A J reported that he didn't know CNA C was on break or that the two other CNAs were in a room and there were multiple call lights sounding. RN-A J reported that he looked down all the halls, did not go to the doors and then returned to the nurse's station to</p>		