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	05/29/2026

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #3026243 and 3926437Based on observations, interviews, and record review, the facility failed to protect the residents' right to be free from physical abuse by another resident for 2 (Resident #2 and Resident #14) of 3 residents review for abuse, resulting in 1. Resident #2 being struck in the head several times, slapped, and kicked in the leg by Resident #22, and experiencing fear and psychosocial harm. 2. Resident #14 being placed in a chokehold (restraining technique in which an arm is tightly wrapped around the neck of another person) by Resident #22 and struck in the head several times.Findings include: Resident #2 Review of an admission Record revealed Resident #2 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: major depressive disorder (common but serious mental health disorder characterized by persistent feeling of sadness, emptiness or loss of interests), anxiety disorder (mental health condition characterized by excessive, persistent and uncontrollable fear or worry), and post-traumatic stress disorder (mental health condition triggered by experiencing or witnessing a terrifying, shocking or dangerous event with symptoms that persist and disrupt daily life). Review of a Minimum Data Set(MDS) assessment for Resident#2 with a reference date of 5/26/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 14/15, which indicated the resident was cognitively intact. Review of a Care Plan for Resident #2 with a reference date of 5/22/26 revealed the following problem/goal/approaches: (Resident #2) has been assessed for the presence of traumatic events in her history and found to have been a victim of trauma. Goal: (Resident #2) will state to social worker if she experiences any traumatic event.Approaches: encourage (Resident #2) to express emotions to.facility social worker in a safe environment, establish trust with resident.behave in a calm manner.provide a calming and reassuring environment. She requests staff check on her though out the HS (night) safety checks. Review of a Trauma Informed Care Observation for Resident #2 with a reference date of 5/27/26 revealed Description.Event 5/23/26.Observation Details.Events: experienced a life-threatening illness, experienced a physical assault, experienced sexual assault(past).Any other very stressful events or experiences? . recent.dementia resident hit me.Comments on event resident was bothered by: I did not have control.How long were you bothered by the event(s)? . bothered by it more than a week.How much did it bother you emotionally? .very much. What are the triggers that remind you of the event? .people coming into my room even if they knock. How do you react when you are reminded (continued on next page)

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	05/29/2026

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	of the event? .mad I wished I had fought back.Additional comments: offer (contractual behavioral health services), wishes staff to check on her though out the night. In an interview on 5/28/26 at 3:00pm, Laundry Aide (LA) X reported he was working in the laundry room across the hall from Resident #2's room on 5/23/26 when he heard a petrifying scream through the laundry room door that caused him to quickly investigate what was happening. LA X reported upon entering the hallway, he saw Resident #22 standing over Resident #2 as she sat in her wheelchair in the doorway to her room. LA X reported he saw Resident #22 punch Resident #2 in her left eye and kick her right shin. Resident #2 was screaming and began yelling Help!. LA X reported he feared for Resident #2's safety and placed himself between her and Resident #22 to stop the altercation. LA X described Resident #2 as scared, borderline terrified, wide-eyed, and shaking after the incident. LA X reported he took Resident #2 to Licensed Practical Nurse (LPN) JJ to report the altercation. In an interview on 5/28/26 at 1:36pm, LPN X reported she was assisting another resident in their room at the time of the altercation between Resident #22 and Resident #2. LPN JJ reported upon walking toward the nurse's station, she was approached by LA X as he pushed Resident #2 in her wheelchair. LPN JJ reported Resident #2 was very upset and told her Resident #22 came into her room and punched her in the left side of her head and kicked her legs. LPN X described Resident #2 as very upset and angry. LPN JJ reported Resident #2 voiced fear that Resident #22 would come into her room again and hit her. In an interview on 5/28/26 at 1:31pm, Resident #2 reported on 5/23/26, Resident #22 tried to come into her room and when she told him to leave, he punched her in the face, then slapped her. Resident #2 reported she extended her right leg to try to keep the resident away and when she did, Resident #22 kicked her leg. Resident #2 reported she yelled Help, he's beating me up! during the altercation and LA X responded. Resident #2 stated I was scared to death, and I don't ever want to see (Resident #22) again. Resident #2 reported the following day, she was very tearful about the incident and stated, it hit me hard that day and I felt vulnerable. Resident #2 reported she remained worried about Resident #22 coming back to her room and assaulting her. In an interview on 5/29/26 at 10:37am, Social Services Coordinator (SS) D reported Resident #2 was emotionally upset and angry when she assessed her psychosocial well-being on 5/27/26, 4 days after the altercation with Resident #22. SS D confirmed Resident #2 already had a history of trauma which could intensify her emotional reaction to the situation. SS D reported she did not know that Resident #22 had a history of physical aggression toward others prior to his recent admission to the facility, and interventions were not in place to address Resident #22's physical aggression toward others. In an interview on 5/28/26 at 3:30pm, Family Member (FM) BB' reported Resident #22 had received a 30-day involuntary discharge notice from the assisted living where he resided prior to coming to the facility. FM BB reported the notice was given as the result of Resident #22 demonstrating ongoing physical aggression toward other residents of the assisted living. FM BB reported Resident #22 was transferred to a local behavioral health hospital due to his physical aggression toward others, where he then fell and was then sent to a local acute care hospital before being accepted for placement at the facility. In an interview on 5/29/26 at 12:05pm, Regional Director of Sales (RDS) EE reported she was acting as the interim liaison for admissions for the facility and reviewed Resident #22 for admission to the facility. RDS EE reported she learned from a case manager in the acute care hospital that Resident #22 was sent to a behavioral health hospital from an assisted living setting after displaying (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	05/29/2026

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	unmanaged agitation. RDS EE reported she was told the assisted living was no longer willing to allow him to reside there. RDS EE confirmed she did not discuss the circumstances surrounding Resident #22's admission to the behavioral health hospital with the resident's family member and the resident could not answer questions. RDS EE confirmed she did not determine the extent of Resident #22's agitation that led to his hospitalization. RDS EE reported she observed Resident #22 while he was in the acute care hospital, and based on a brief observation, felt his care needs could be managed at the facility. RDS EE reported it was the expectation the facility would review the referral materials to determine if the resident's care needs could be met at the facility. In an interview on 5/29/26 at 1:28pm, Nursing Home Administrator (NHA) A reported the facility was aware Resident #22 had been hospitalized in a behavioral health hospital prior to coming to the facility but did not inquire about his behavioral health needs prior to his admission. NHA A reported she assumed Resident #22 went to the behavioral health hospital for medication management but did not inquire about the resident's behaviors that resulted in hospitalization. NHA A reported after Resident #22 punched and kicked Resident #2 on 5/23/26, the facility learned he had been hospitalized in the behavioral health hospital for similar behavior toward fellow residents in the assisted living where he previously resided. Review of an Abuse Prevention Program policy with a reference date of 1/26 revealed (Corporation Name) has prevention programs in which policies and procedures safeguard our residents to be free from abuse.abuse is defined as the willful infliction of injury.willful, means the individual .acted deliberately.having a.cognitive impairment does not automatically preclude a resident from engaging in deliberate.actions.Physical abuse includes.hitting, slapping, punching.kicking.Screening of prospective residents will be conducted to determine whether the facility has the capability to provide the necessary care and services for each resident admitted . The procedure includes, but is not limited to. a. An assessment of the functional and mood/behavior status. Resident #14: Review of a Face Sheet revealed Resident #14 was a female with pertinent diagnoses which included dementia (a term for several diseases that affect memory, thinking, and the ability to perform daily activities), stroke, paralysis, dysphagia (difficulty swallowing), malnutrition, need for assistance for personal care, and speech impairment. Review of Progress Notes dated 05/26/2026 at 05:13 PM, .400pm DON (Director of Nursing) notified of another resident hitting (Resident #14) in the face and head. Residents were immediately separated by staff. Skin assessment completed by charge nurse (Licensed Practical Nurse (LPN) GG). DON observed a raised, red/purple area on (Resident #14's) L (left) proximal (central) cheek bone 3cm (centimeter) x 2cm.received orders to monitor bruised area and recheck skin on 5/27/26 for any additional bruising or injury. Review of Incident Summary dated 5/26/26, revealed, .On 5/26/26 at approximately 3:30 pm, staff reported to administrator that there had been a resident-to-resident physical abuse altercation. Staff witnessed (Resident #22) making contact with (Resident #14)'s right (injury was on the left) side of (her) head with a closed hand.(Resident #22) was placed back on 1:1 supervision. Skin assessment completed of (Resident #14), no obvious bruising noted yet but will continue to monitor for changes.(Resident #22) had been on 1:1 supervision from 5/23/26, up until 6am this morning, 5/26/26, r/t (related to) another allegation of abuse still in the investigation process. New order was (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	05/29/2026

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	obtained for Ativan PRN (as needed) during this time frame.this medication has a history of being effective in (Resident #22)'s past behavioral situations.Order obtained to send (Resident #22) to ER for psych evaluation. Review of Skin assessment dated [DATE] at 6:20 PM, revealed, .pt (patient) has bruising under L (left) eye. Pt has soreness on back and neck but no visible scarring, likely to bruise given skin integrity and force . During an observation and an interview on 05/27/2026 at 1:41 PM, Resident #14 reported Resident #22 had come into her room while she was eating some dark chocolate, and she had not been paying attention. Resident #14 reported he had mental problems and he belonged somewhere other than at the facility. She reported the facility had sent Resident #22 to the hospital. Resident #14 reported as Resident #22 was at the hospital she was not concerned for her safety but would be if he came back to the facility. Observed a red/pinkish area on her left upper cheek area approximately the size of a quarter. Review of Progress Note dated 05/27/2026 at 06:24 PM, .(Resident #14) when assessed her for trauma from the 05-26-2026 event she said she was more PO'd (pissed off) that the resident (Resident #22) caught her off guard. She told this social worker I was enjoying my piece of dark chocolate and then he came into my room, that's when he hit me. She knows this resident will not be returning to (Facility). Review of Progress Note dated 05/27/2026 at 12:27 PM, .Skin assessment finds redden area above L cheek bone, painful to touch. In an interview on 05/28/2026 at 11:40 AM, Certified Nursing Assistant (CNA) T reported everything happened so fast, she had just gone by Resident #22's room and he was in his room. Then (Resident #14) was in the hallway, crying bawling her eyes out. CNA T reported (Resident #22) moved so fast, he was quick and it was hard to keep an eye on him. CNA T reported Resident #22 had walked around constantly, and he was constantly at the exits, had to hurry up and get him, it was hard to try to supervise him and also give care to the other residents. CNA T reported one second he was down in bed and then he was up and in another resident's room. CNA T reported once the residents were separated and CNA P was assisting Resident #14 to the nurse's station; Resident #22 had hopped into bed with another resident whose room was across from his and next to Resident #14's room. CNA T reported he was redirected to his room and went to figure out what the DON wanted to do with Resident #22. During an observation on 05/29/2026 at 10:39 AM, Resident #14 had a redness/pinkish area under her left eye on her cheek bone. The area was approximately the size of a nickel. Resident #22: Review of an admission Record revealed Resident #22 was a male with pertinent diagnoses which included dementia. Review of Progress Note dated 05/12/2026 at 7:30PM PM, .Resident noted to be confused and disoriented during the shift. He was observed ambulating into another resident's room unclothed and displaying inappropriate behavior toward the resident occupying the room. (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	05/29/2026

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	Review of Progress Note dated 05/13/2026 at 04:01 PM, .(Resident #22) is a new admit with primary dx (diagnosis) of Multiple L (left) Rib Fractures after a fall. He also has fx (fracture) of the R (right) clavicle (collarbone) with dislocation.Has recently been in (Local Behavioral Unit at hospital) for treatment r/t (related to) Severe dementia. He is A&O (alert & oriented) x1 (to self) and has been walking in the hall independently without purpose. These are new surroundings for the resident, and he did go into other rooms.confusion of surroundings and severe dementia and frequent checks initiated per policy. 15 minutes checks discontinued. (Resident #22) admitted on Seroquel without current diagnosis. Provider aware and will evaluate record to determine need at initial visit. Note: Resident #22 did not have Seroquel as a prescribed medication upon admission. Review of Progress Note dated 05/15/2026 at 9:12 PM, .Resident wandering the halls in and out of resident's rooms, pushing on exit door next to room. Review of Resident Profile start date of 5/16/26, revealed, .Do not approach (Resident #22) from behind or the side he will startle and may strike out. Review of Progress Note dated 05/19/2026 at 08:00 AM, .Received pharmacy recommendation r/t (related to) Risperdal usage.discontinued Risperdal (on 5/19/26). Review of Progress Notes dated 05/21/2026 at 01:55 PM, .Resident continues to wander throughout facility and into other resident's rooms.Resident is placed on 15min checks. active working wander guard placed on the R (right) ankle. Review of Progress Notes dated 05/22/2026 at 10:10 AM, .Resident alert and oriented to self, confusion.Resident continues to wander throughout facility and into other resident's rooms.Resident walks independently throughout facility. Review of Progress Notes dated 05/23/2026 at 05:40 AM, .Resident oriented to self, very confused. Wanders in and out of rooms throughout the evening into the late hours. After so many redirections, resident becomes angry and pushing at staff.Resident wants to follow staff into rooms. Review of Progress Note dated 05/23/2026 at 07:14 PM, .Writer in assisting with new admission when loud outburst heard in hallway. Resident had taken another resident's phone and would not return it.After multiple attempts phone was returned.another resident and staff member approached nursing station to report an incident involving (Resident #22).wandered into another resident's room and became aggressive hitting her on the left side of her head, lt (left) side of her face and kicking her in her rt (right) leg below the knee.resident pulled out penis and began to void in the corner of the nursing station. Review of Progress Notes dated 05/24/2026 at 06:45 PM, .Resident wandering into other residents' rooms and throwing objects on floor. This nurse redirected resident to hallway and offered snack/puzzle to resident until caregiver present. Review of Skilled Note dated 05/24/2026 at 11:16 PM, .Resident alert and oriented to self, he spent the shift wandering the halls and required frequent redirection from staff.Staff provided continuous 1:1 supervision throughout the shift due to increased behaviors and safety concerns. Resident attempted to hit staff on a couple of occasions. Review of Progress Note dated 05/26/2026 at 12:06 PM, Resident continues to wander throughout (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	05/29/2026

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	facility and into other resident's rooms.really confused.currently on 15 min checks. Review of Progress Note dated 05/26/2026 at 03:22 PM, Pt (Patient) combative at 1515 (3:15 PM). Pt was witnessed assaulting another pt. Putting her in a headlock and punching her several times in the face. Pt was removed from other pts room. Placed on 1:1. In an interview on 05/28/2026 at 12:09 PM, CNA R reported when she worked on Sunday (5/24/26), Resident #22 was on a one on one for supervision. In an interview on 05/28/2026 12:53 PM, CNA KK reported he was taken off his assignment to be on a one on one with (Resident #22). CNA KK reported Resident #22 walked the hallways, attempted to wander in different residents' rooms, and was queued back to his room. In an interview on 05/29/2026 at 11:01 AM, LPN GG reported the day (5/26/2026) of the incident involving Resident #14 and Resident #22, she was sitting at the nurse's station with the other nurse as it was shift change, reported she would be the only nurse on the floor. LPN GG reported she had heard someone yelling out, Hey, Hey, Hey what are you doing? CNA came up to the nurse's station with (Resident #14) and reported (Resident #22) had her in a head lock and was punching her in the face. LPN GG reported she had another staff member stay with Resident #22 in his room. LPN GG reported Resident #14 was really upset. (Resident #22) was given an as needed dose of Ativan. LPN GG reported she assessed (Resident #14)'s skin, neck and face areas and her left eye had a mark under it, she was sore likely to bruise as she was so frail, no immediate bruising noted on her face. LPN GG reported the wandering into other residents' rooms was not new for (Resident #22) and he would have to be reminded to not go in their rooms and/or the residents were yelling at him to get out. LPN GG reported the EMS staff who reported already knew (Resident #22) from another facility due being transported for evaluation due to his behaviors. LPN GG reported after the PRN Ativan, he was still a little combative and did not cooperate to get on the stretcher before being taken for evaluation. In an interview on 05/29/2026 at 12:13 PM, CNA P reported when the incident happened between Resident #14 and Resident #22 on 5/26/2026, she had just cleaned up pee on Resident #22's floor in his room, and she was walking down the hallway towards the nurse's station to grab a hoyer to assist another resident out of bed. CNA P reported she had heard yelling, Call 911, Call 911! Help me! and when she arrived in Resident #14's room she observed Resident #22 had Resident #14 in a head lock with his arm around her head and he was punching her in the face, not light hits either, he got her 3 times hard in the face that she saw. CNA P' reported she had placed her body over Resident #14 to protect her from getting punched in the face and he continued to punch striking her on her back. While CNA P was pushing Resident #14 out of the room to get her away from him, Resident #22 then grabbed the call light, swung it at her and hit her (CNA P) in the head with it. CNA P reported she transferred Resident #14 to the nurse's station and went back down the hallway and observed Resident #22 was lying in bed with another resident whose room was next to Resident #14's room. CNA P reported a few days after Resident #22 had admitted he had swung at a nurse and struck her in the face, and he had assaulted another resident a few days before he assaulted Resident #14. CNA P reported the behavior was not new for Resident #22. In an interview on 05/29/2026 at 2:56 PM, Director of Nursing (DON) B reported the decision to place a resident on 15 minute checks was determined by behaviors when the resident was removed from 15 minute checks. The interdisciplinary team (IDT) discussed the observations, staff discussions, and behaviors and made a decision to remove the resident from 15 minute checks based on that information. DON B reported she went to the nurse's station to assess Resident #14 and determine (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	05/29/2026

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	what had happened. DON B reported it was reported Resident #22 had struck Resident #14 several times in the face in her room.

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	05/29/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate staffing to promote the physical, mental, and psychosocial well-being in 2 of 12 residents (Resident #22 & #26) reviewed for staffing, resulting in unmet care needs and the potential for physical and psychosocial harm for all residents in the facility. Findings include: Resident #22 Review of an admission Record revealed Resident #22 was a male with pertinent diagnoses which included dementia. Review of Care Plan for Resident #22 on 5/16/26 revealed the focus, .(Resident #22) is at risk for elopement related to memory deficit confusion and inability to read or write due to Alzheimer's. with the intervention .Calmly redirect and divert resident's attention when showing signs of exit seeking. Do not approach (Resident #22) from behind or the side he will startle and may strike out. In an interview on 05/29/2026 at 11:01 AM, Licensed Practical Nurse (LPN) GG reported providing supervision for Resident #22 was very problematic as he was wandering in other residents' rooms and this was causing concerns, residents were yelling at him to get out of their rooms, and he was going through his roommate's dresser. LPN GG reported he was exit seeking and would go to the exit doors. He was always wandering during the day, and staff would have to ensure not to leave anything where he could obtain it to keep him safe. LPN GG reported Resident #22 was someone who would benefit from more one to one staffing as he was ambulatory and it was difficult to do the job you were there for and keep an eye on him to keep him safe as well as other residents. In an interview on 05/29/2026 at 11:01 AM, LPN GG reported she was sitting at the nurse's station as it was shift change and she was the only nurse on the floor for second shift. Incident occurred on 5/26/26 at approximately 3:30 PM involving Resident #22 and Resident #14. In an interview on 5/28/26 at 11:26am, CNA S reported Resident #22 needed more supervision that the facility could provide on 5/23/26 and as a result, he had a physical altercation with another resident. CNA S reported Resident #22 always needed a staff member with him in order to remain safe. In an interview on 5/28/26 at 12:04pm, CNA R reported at times the facility could not fill openings in the schedule when a staff member called off. This resulted in staff members rushing during cares, working through lunch breaks, and not being able to address the residents' psychosocial needs. CNA R reported she regularly cared for 13-14 residents on her own. CNA R reported the facility could not provide the type of supervision Resident #22 needed and that resulted in him wandering in and out of other residents' rooms, resident's yelling at him and physical altercations between him and other residents. In an interview with Licensed Practical Nurse (LPN) JJ on 5/28/26 at 1:36 pm reported Resident #22 wandered all day on 5/23/26 and was frequently in and out of other residents' room. LPN JJ reported the staff tried to supervise him as much as possible but could not provide the constant supervision the resident needed that day. LPN JJ reported due to lack of supervision, Resident #22 had a physical (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	05/29/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	altercation with another resident. Review of incident reports for Resident #22 revealed he initiated resident to resident altercations on 5/23/26 at 3:20pm. Review of the working nursing/CNA schedules for 5/23/26 revealed at the time of the incident involving Resident #22, the facility 1 nurse and 2 CNAs in the building. The facility had 3 CNAs scheduled to be present but 1 called in a replacement was scheduled to come in at 4:30pm. Of note, 12 facility residents required assist of 2 staff members for transfers so if staff were assisting one of those residents, the remaining residents throughout the facility were being supervised/care for by one staff member. In an interview on 5/28/26 at 3:30pm, Family Member (FM) BB reported the facility initiated 1:1 supervision for Resident #22 on 5/23/26 after a resident to resident altercation, but she received a call on 5/26/26 at 3:28pm from Licensed Practical Nurse (LPN) GG who informed her the resident would not receive 1:1 supervision on this date due to staffing issues. FM BB reported she was concerned Resident #22 would have another altercation with a resident. Review of an Incident Report for Resident #22 with a reference date of 5/26/26 at 4:44pm, revealed Resident #22 grabbed a female resident in a choke hold (restraining technique in which an arm is wrapped tightly around another person's neck) and punched her in the face, chest and upper back multiple times. Review of the working nursing/CNA schedule for 5/26/26 revealed the facility was staffed with 1 nurse and 3 CNAs at the time of the incident involving Resident #22. In an interview on 5/29/26 at 10:06am, Scheduler/CNA E reported at times the facility could not fill a shift when a staff member called in. Scheduler/CNA E reported the facility currently has 16 CNAs on staff with 4 positions open. Scheduler/CNA E reported he had worked every day for the last 8 weeks, because he filled in as a CNA on the weekends due to staffing shortages. Scheduler/CNA E reported the current recommended staffing level for the afternoon/evening shift was 1-2 nurses and 2-3 CNAs, any 1:1 supervision of residents would be in addition to these numbers. Resident #26 Review of an admission Record revealed Resident #26 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: dependence on wheelchair and other reduced mobility. Review of a Minimum Data Set(MDS) assessment for Resident #26 with a reference date of 4/1/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Review of a Care Plan for Resident # 26 with a reference date of 4/22/25 revealed the following problem/goal/approaches: Problem: Alteration in ADLs (activities of daily living) . Goal: .Care needs will be met. Approaches: (Resident #26) requires a sit to stand mechanical (mechanical lift device that requires 2 staff for safe use) for transfers.involve resident in care and decision making as much as possible.Resident uses a wheelchair for mobility. (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	05/29/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 4/27/26 at 7:29am, Resident #26 was lying on his back in his bed. Resident #26 reported he wanted to get up for the day. Resident #26 was encouraged to activate his call light and did so at this time. During an observation on 4/27/26 at 7:31am, a staff member entered Resident #26's room, deactivated his call light and told the resident she would go get help to transfer him out of bed. During an observation on 4/27/26 at 7:34am, Resident #26 reactivated his call light while he remained in bed. During an observation on 4/27/26 at 7:38am, a staff member entered Resident #26's room, deactivated his call light and told the resident to give me a couple of minutes regarding his desire to get out of bed. During an observation on 4/27/26 at 7:44am, Resident #26 reactivated his call light. A staff member entered the room and deactivated the call light at 7:59am. During an observation on 4/27/26 at 8:02am, Resident #26 remained in bed and reactivated his call light at this time. During an observation on 4/27/26, Resident #26's call light remained activated until 8:17am when another staff member entered the resident's room, deactivated the call light and stated she was going to grab (staff member's name omitted) to help her transfer the resident. During an observation on 4/27/26 at 8:23am, 54 minutes after Resident #26 initially activated his call light to get out of bed, 2 staff members arrived to assist him with transferring from his bed to his wheelchair. In an interview on 5/28/26 at 3:00pm, Resident #26 reported he regularly experienced long call light wait times of greater than 30 minutes and frequently had to reactivate his call light because staff would turn it off without completing the care he needed. Resident #26 reported the facility frequently did not have enough staff to ensure residents received care promptly, especially those who needed the assistance of 2 staff members, and he was frustrated by the situation. Review of a 2-person bed mobility and transfers list provided by the facility, revealed 4 residents required assistance of 2 staff for bed mobility and 12 residents required assistance of 2 staff for transfers, including Resident #26. The census for the facility was 35 residents. In a confidential meeting on 4/28/26 at 2:00pm, 4 of 7 residents in attendance reported long call light wait times of greater than 30 minutes, resulting in feelings of frustration. Residents reported the facility frequently could not find a replacement when someone called off and this resulted in having to wait for longer periods of time to get help. 7 of 7 residents reported they experienced an unsupervised resident with advanced dementia wandering into their room. Review of a Payroll Based Journal Report revealed the facility was triggered for excessively low weekend staffing during the first quarter, October-December 2025. Review of an electronic communication with a reference date of 5/28/26 at 11:16am revealed confirmation from Chief Operating Officer (COO) NN the facility reported low weekend staffing for the (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	05/29/2026

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	first quarter, October-December 2025. In an interview on 05/28/2026 at 11:40 AM, Certified Nursing Assistant (CNA) T reported not all the time are we staffed the way we should be. CNA T reported it was very difficult to keep an eye on Resident #22 especially when the facility was not fully staffed. CNA T reported weekends were the worst as at times it was her and another CNA covering the resident's care. CNA T reported quite a bit of the time she missed breaks, worked through her lunch to be able to provide care to the residents. CNA T reported she was not able to spend as much time with each resident as she would like as she was always running from one resident to another, she was not able to sit and have conversations with residents, have to tell them she would be back and a lot of times hardly able to have a chit chat with residents. CNA T reported sometimes we were the only people the resident had and not being able to spend a few minutes with them talking to them could cause them to feel loneliness. In an interview on 05/28/2026 at 12:04 PM, CNA R reported staffing not able to always cover call ins for a shift. CNA R reported when the missing slot was not filled, the staff feel they weren't able to provide the quality of care and have to prioritize, sometimes only able to give a bed bad instead of a full shower. CNA R reported when this happened staff were not able to do as much as they would like to and would just have to work through it and do what they could as it was crazy busy. In an interview on 05/28/2026 1:23 PM, Maintenance Director (MD) E reported he worked as a CNA (Certified Nursing Assistant) quite a bit lately more than he would like to. MD E reported he would come in early for those staff members who were mandated over or who were to come in early to work for an earlier shift. MD E reported most of the time he worked weekends to cover call ins. MD E reported the facility had small building problems such as when a nursing staff member called in that was 30% of the floor staff so it affects the building more than it would if it was a larger building.

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	05/29/2026

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 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** This citation pertains to intakes #3026243, #3026437Based on interview and record review, the facility failed to develop and implement person centered dementia care interventions to address needs for 1(Resident #22) of 5 residents reviewed for dementia care, resulting in Resident #22 demonstrating symptoms of unmet care needs which included ongoing wandering, exit seeking, physical aggression toward others and rehospitalization.Findings 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. Resident #22 Review of an admission Record revealed Resident #22 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia (an umbrella term for a decline in mental abilities severe enough to interfere with daily life). Review of a Care Plan for Resident #22 with a reference date of 5/16/26 revealed the following problems/goals/approaches: 1. Problem: Severe impaired cognitive function related to diagnosis of Alzheimer's (progressive, irreversible brain disorder that results in loss of memory, thinking skills, and the ability to carry out the simplest tasks). Goal: Resident will have reduced complications.related to his cognitive function.Approaches: Administer medications as ordered, do not overwhelm resident with too many choices, keep resident's routine as consistent as possible. 2. Problem: (Resident #22) is at risk for elopement related to memory deficit, confusion and inability to read or write due to Alzheimer's. Goal: (Resident #22's) safety will be maintained.Approaches: Calmly redirect and divert resident's attention when showing signs of exit seeking. Do not approach (Resident #22) from behind.Distract (Resident #22) .by offering pleasant diversions, structured activities.books.he was the head of the treasury department.give him papers to sort or loose binders to hold, ask him to assist you. Of note, the care plan did not address Resident #22's episodes of physical aggression toward others. In an interview on 5/29/26 at 10:37am Social Services (SS) D confirmed she was responsible for dementia care interventions for the residents at the facility. SS D reported she did not really know Resident #22 very well, didn't know his likes and dislikes or specific activities that might catch his attention. SS D reported she did know one statement that was useful in redirecting Resident #22, but it had not been added to his care plan. SS D reported Resident #22 displayed nearly constant wandering from the time of his admission to the facility. SS D reported Resident #22 repeatedly set off the exit alarm on the door near his room. SS D reported it seemed like Resident #22 did not know where he was and she planned to ask his wife to bring in familiar items to place in his room but hadn't gotten to it yet. SS D reported upon admission, Resident #22 was not monitored to determine what triggered his wandering or his other behaviors. When queried about what triggered Resident #22's restlessness, wandering, and physical aggression, SS D reported it was Just his dementia, we don't know. SS D confirmed Resident #22 had two episodes of physical aggression directed toward other residents and several toward staff prior to being discharged back to the hospital due his unmanaged behaviors. SS D reported Resident #22 had not been evaluated by the facility's contractual behavioral health provider. (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	05/29/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed Resident #22 had resident-to-resident altercations on 5/23/26 and 5/26/26. In an interview on 5/28/26 at 1:36pm, Licensed Practical Nurse (LPN) JJ when she cared for Resident #22 on 5/23/26, the resident wandered all day and was frequently in and out of other residents' room. LPN JJ reported the staff tried to meet his needs that day but were not successful. LPN JJ reported Resident #22 was wandering around the facility when he approached another resident in her doorway and became physically aggressive toward her. LPN JJ reported immediately after the incident, Resident #22, who had been continent, urinated in the hallway. LPN JJ confirmed Resident #22 could not verbalize his needs and may have been stressed because he needed to urinate and did not know where his bathroom was. In an interview on 5/28/26 at 11:26am, Certified Nursing Assistant (CNA) S reported Resident #22 could not verbalize his needs and constantly wandered around the facility, including going in and out of other residents' rooms. CNA S reported she witnessed several occasions in which other residents yelled Get out! at Resident #22 as he entered their rooms. CNA S reported she tried to engage Resident #22 in activities to reduce his wandering, but did not know what he liked, and was not successful. In an interview on 5/28/26 at 12:04pm, CNA R reported Resident #22 wandered constantly and frequently went into other residents' room and tried to remove his pants. CNA R reported she did not know how to meet his needs and felt he always needed a staff member with him, but that was not possible. In an interview on 5/28/26 at 3:30pm. Family Member (FM) BB reported Resident #22 was admitted to a behavioral health hospital on approximately 5/2/26 due to episodes of physical aggression; Resident #22 was injured there, then admitted to an acute care hospital prior to coming to the facility. FM BB reported she had been very open with the facility about Resident #22's need for dementia care interventions and close supervision. In an interview on 5/29/26 at 1:28pm, Nursing Home Administrator (NHA) A reported Resident #22 came to the facility following an admission to an acute care hospital after a fall at a behavioral health hospital. When queried, NHA A reported she did not inquire about why Resident #22 was initially hospitalized in a behavioral health hospital. NHA A confirmed the facility must be aware of each residents' history to provide resident centered care. NHA A reported upon admission to the facility, Resident #22 wandered frequently, needed increased supervision and became combative toward staff when he was redirected too often. NHA A reported she later learned, prior to his admission to the facility, Resident #22 had been admitted to the behavioral health hospital due to stress responses that included physical aggression toward others. NHA A reported ultimately, Resident #22 was sent back to the acute care hospital following his second altercation with another resident. Review of a Care of a Resident with Dementia policy with a reference date of 1/25 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 for the resident with Dementia: It is important to have an accurate assessment of the residents past life and current diagnosis.IDT (Interdisciplinary Team) should meet to discuss.best interventions needed for the specific resident.Ensure you are providing a patient centered care environment by communicating with the resident and or family. (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	05/29/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Progress Note dated 05/26/2026 at 03:22 PM, .Pt (Patient) combative at 1515 (3:15 PM). Pt was witnessed assaulting another pt. Putting her in a headlock and punching her several times in the face. Pt was removed from other pts room. Placed on 1:1. On 10 (sic) minute checks was last observed making up bed within last 10 minutes . Review of Activity Note dated 05/15/2026 at 03:44 PM, .(Resident #22) has a dx (diagnosis) of dementia. He is married and has been for 51 years. He was an accountant .he has sat and listened to music . This intervention was not added to the resident's profile or care plan. Review of Progress Note dated 05/19/2026 at 08:00 AM, Received pharmacy recommendation r/t (related to) Risperdal usage.discontinued Risperdal as was used for sleeping per wife . Review of Orders for Resident #22 revealed, .risperidone tablet; 0.5 mg; amt: 1; oral Twice A Day; 07:00 AM - 11:00 AM, 07:00 PM - 11:00 PM .discontinued on 5/19/26. Risperidone is an atypical antipsychotic medication used to rebalance dopamine and serotonin (brain chemicals that regulate mood, emotion, and behavior) to improve thinking, mood, and behavior .it may take 2-3 months before you would feel the full effects of the medication .symptoms continue to get better the longer you take risperidone .do not stop taking risperidone suddenly, a gradual withdrawal when discontinuing to avoid acute withdrawal syndrome. https://www.nami.org/treatments-and-approaches/mental-health-medications/types-of-medication/risperidone- In an interview on 05/29/2026 at 11:01 AM, Licensed Practical Nurse (LPN) GG reported providing supervision for Resident #22 was very problematic as he was wandering in other resident's rooms and this was causing concerns, residents were yelling at him to get out of their rooms, and he was going through his roommate's dresser. LPN GG reported he was exit seeking and would go to the exit doors. Resident #22 was always wandering during the day and staff would have to ensure not to leave anything where he could obtain it to keep him safe. LPN GG reported Resident #22 was someone who would benefit from more one to one staffing as he was ambulatory and it was difficult to do the job you were there for and keep an eye on him to keep him safe and others. In an interview on 05/29/2026 at 1:39 PM, LPN J reported she would have Resident #22 walk with her and be with her where she went in the building as it was easier for her to do her job and to be able to keep an eye on him. LPN J reported Resident #22 was placed on 15-minute checks a few times during his stay at the facility. LPN J reported Resident #22 had attempted to hit her, was able to redirect him, and he tried to slap her again. LPN J reported he had a sitter and attempted to beat up the sitter so the facility had to send in a male CNA to sit with him. LPN J reported quite a few residents were complaining about Resident #22 walking into their rooms, and it was causing a problem. LPN J reported Resident #22 was having a decline and she was unsure if something medical was happening. LPN J reported he was not on a scheduled anxiety medication to help with his anxiousness and wandering and she was surprised he was not prescribed one. After he had assaulted another resident, he was prescribed Ativan as an as needed anti-anxiety medication. In an electronic correspondence from Nursing Home Administrator A reported there was not a true education schedule and the learning program was self paced. Review of completion report requested completed educations since last recertification survey for Dementia Care revealed several staff members from all areas of concentration had not completed the required training; Dementia Hand in Hand training, Dementia Care: Maintaining Routines and (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	05/29/2026

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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Consistency, Nursing Management -Dementia Related Behaviors, and Dementia Person Centered Care Plans.