

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 05/29/2026
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)		
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to ensure infection control data was regularly analyzed during QAPI (Quality Assurance and Performance Improvement) meetings and completed at least one PIP (Performance Improvement Plan) related to quality issues identified by the quality assessment and assurance committee, resulting in the potential for systematic failures related to infection control and other quality deficiencies. Findings include: Review of the facility policy Quality Assurance and Performance Improvement (QAPI) dated 1/2026 revealed, . Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program, are necessary. c. Develop and implement appropriate plans of action to correct identified quality deficiencies. d. Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. e. The QAA committee must sign to verify approval of all plans of correction written.c. The facility conducts at least one distinct performance improvement project (PIP) annually that focuses on high risk or problem prone areas. Additional projects may be conducted as needed, and may be clinical or non-clinical in nature.In an interview on 05/29/2026 at 10:09 AM, Nursing Home Administrator (NHA) A reported that QAPI meetings are held at least monthly. NHA A reported that the facility did not have an Infection Preventionist (IP) in attendance since January 2026. NHA A reported that Regional IP FF started in March 2026 but was working from afar and did not attend any of the QAPI meetings. NHA A reported that infection control data had not been submitted for review and was not included in the QAPI meeting minutes.Review of the QAPI meeting sign in sheets from February-May 2026 revealed the Infection Preventionist (IP) was not in attendance.Review of QAPI data submitted from February-May 2026 revealed there was no data related to infection control, except the pharmacy list of antibiotics.In an interview on 05/29/2026 at 12:33 PM, NHA A reported that she would look for documentation from any PIP's (Performance improvement project) from the past 12 months. No documentation was provided prior to survey exit.Review of the provider history report revealed the facility had been cited for in 2023, 2024, and 2025 during the annual surveys for infection control non-compliance.		

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

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 05/29/2026
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)		
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) attended the QAPI (Quality Assurance and Performance Improvement) meetings, resulting in the potential for lack of resident care policies and overall medical care that could affect all residents residing in the facility. Findings include: Review of the facility policy Quality Assessment and Assurance Committee dated 1/2022 revealed, .The Committee will be composed of staff who understand the characteristics and complexities of the care and services delivered in each unit and/or department. The QAA committee will be composed of, at a minimum: a. The Director of Nursing. b. The Medical Director or his/her designee. c. At least three (3) other facility staff members, one of which will be the administrator, owner, a board member or other individual in a leadership role. d. The Infection Preventionist (IP). 2. The infection preventionist must be a member of the QAA committee and report to the committee on the infection prevention and control program (IPCP) and incidents (e.g., healthcare-associated infections (HAIs) identified under the program on a regular basis. a. Reporting may include, but is not limited to: i. Facility process and outcome surveillance; ii. Outbreaks (ongoing and any since the last meeting) and control measures; iii. Occupational health communicable disease illnesses (e.g., TB, influenza) iv. The Antibiotic Stewardship Program (ASP) related to antibiotic use and resistance data. b. The infection preventionist should attend each QAA meeting, but if the IP cannot attend, another staff member should report on the IP's behalf. This does not change or absolve the IP's responsibility to fulfill the role of QAA committee member or reporting on the IPCP. In an interview on 05/29/2026 at 10:09 AM, Nursing Home Administrator (NHA) A reported that QAPI meetings are held at least monthly. NHA A reported that the facility did not have an Infection Preventionist (IP) in attendance since January 2026. NHA A reported that Regional IP FF started in March 2026 but was working from afar and did not attend any of the QAPI meetings. NHA A reported that infection control data had not been submitted for review and was not included in the QAPI meeting minutes. Review of the QAPI meeting sign in sheets from February-May 2026 revealed the IP was not in attendance.		

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 05/29/2026
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)		
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)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 05/29/2026
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)		
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: 235637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2026
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)		
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: 235637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2026
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)		
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 bath 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.		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 05/29/2026
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)		
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to promote dignity and respect in 2 residents (Resident #25 & #5) from a total sample of 20 residents, resulting in long call light wait times and the potential for feelings of diminished self-worth, sadness, and frustration. Findings include: Resident #25 Review of an admission Record revealed Resident #25 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #25, with a reference date of 3/9/26 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #25 was cognitively intact. Review of Resident #25's Functional Abilities indicated that she was dependent (helper does all the effort) on staff for toileting. During an observation on 05/28/2026 at 1:22 PM Resident #25's call light was observed on. At 1:29 PM Certified Nursing Assistant (CNA) Q entered Resident #25's room, turned the call light off and told the resident that she would let her (Resident #25's) CNA know that she needed to use the toilet. At 1:38 PM CNA Q entered the room closed the curtain and was providing care to Resident #25's roommate. In an interview on 05/28/2026 at 1:35 PM, Resident #25 reported that she needed to be changed now because she was wet. Resident #25 was in a rush because she wanted to attend a meeting in the dining room at 2:00 PM. In an interview on 05/28/2026 at 3:53 PM, Resident #25 reported that she feels at the mercy of the facility, she did not have time to use the toilet earlier and had to settle with having her brief changed because she waited so long. Resident #25 reported that she waits up to 2 hours for her call light and/or needs to be met. Resident #25 reported that staff frequently turn her call light off and then don't come back. Resident #5 Review of an admission Record revealed Resident #5 was originally admitted to the facility on [DATE]. Review of the Minimum Data Set (MDS) assessment for Resident #5, with a reference date of 5/18/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #5 was cognitively intact. Review of Resident #5's Functional Abilities indicated that he required substantial/maximum (helper does more than 50% of effort to perform task) assistance with toileting. In an interview on 05/27/2026 at 11:57 AM, Resident #5 reported that when he puts his call light on, they either don't answer it or don't come back. During an observation and interview on 05/28/2026 at 1:10 PM Resident #5's call light was observed on. At 1:14 PM CNA O yelled from the hall that she would be right there. At 1:30 PM (20 minutes later) CNA Q entered Resident #5's room, and Resident #5 requested to use the bathroom. CNA Q turned the call light off, gave him a urinal and walked out of the room. At 1:31 Resident #5 put his call light on and reported to this surveyor that he needed the urinal removed from between his legs. At 1:45 PM Resident #5's call light was answered. In an interview on 05/29/2026 at 10:09 AM, Nursing Home Administrator (NHA) A reported that the expectation was that staff leave a call light on until the need was met. NHA A reported that it had been quite a while since the facility had performed call light audits and it had not been a topic brought to the monthly QA (quality assurance) meetings.		

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 05/29/2026
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)		
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review the facility failed to perform an assessment for self-administration of medication, obtain an order, and update the care plan for 2 residents (Resident #15, #33) of 12 Residents reviewed for self-administration of medications, resulting in the mismanagement of medications with a potential for adverse side effects. Findings include: Resident #15: Review of an Face Sheet revealed Resident #15 was a female with pertinent diagnoses which included cognitive communication deficit (person struggles to communicate due to underlying impairments in mental processes), encephalopathy (disease, damage that affects the function of the brain), Adjustment disorder with mixed disturbance of emotions and conduct (reaction to an event causes more intense distress than normally would be expected), and moderate intellectual disabilities. During an observation and interview on 05/27/2026 at 7:32 AM, observed what appeared to be two crushed medications (one orangish, one yellowish in appearance) in a medication cup on the nightstand next to Resident #15's bed. Resident #15 had a small cup of water on the nightstand. Resident #15 also had an empty medication cup on her rolling bedside table. Review of Care Plan for Resident #15 dated 10/23/2024, revealed the focus, .Psychosocial Well-Being .(Resident #15) has a decision-making impairment R/T (related to) developmentally delayed. (Resident #15) has a court appointed guardian . Review of Resident #15's medical record revealed no orders, self-administration assessment, or updated care plan which allowed Resident #15 to take her medications independently without supervision. In an interview on 05/29/2026 at 10:26 AM, Resident #15 reported the staff took the medication, which was on her nightstand and threw it away. Resident #15 reported the nurses do bring her medication and leave it for her to take when she wants, They do that quite a bit. In an interview on 05/27/2026 at 2:07 PM, Licensed Practical Nurse (LPN) II reported when she entered Resident #15's room she noticed the crushed medications in a medication cup on the nightstand and she removed the medications. LPN II reported Resident #15 doesn't take her medications crushed and reported she could not determine what each of the medications were in the cup as there were two different colored medications in the cup. Resident #33: Review of Face Sheet revealed Resident #33 was a female with pertinent diagnoses which included multiple sclerosis (chronic, autoimmune disorder of the central nervous system) pressure ulcer sacral region (large triangular bone at the base of the spine) stage 4 (severe life threatening injury with tissue loss with exposed bone, muscle, tendon, or ligaments), muscle weakness, paralysis, dependence on wheelchair, diabetes, and heart failure. In an interview on 05/27/2026 at 8:40 AM, Resident #33 reported the medication cup with the room and bed number on it on her rolling bedside table was for medications the nurses had given her. Resident #33 reported the nurses leave her medication with her to take when she was ready as they do not need to stand over her. Resident #33 reported all the nurses leave her medication with her to self-administer.Review of Resident #33's medical record revealed no orders, self-administration assessment, or updated care plan which allowed Resident #33 to take her medications independently without supervision. In an interview on 05/29/2026 2:50 PM, Director of Nursing (DON) B reported in order for the resident to self-administer medications there would be an order in the medical record and a care plan would be implemented for self-administration of medications otherwise the resident should not be allowed to self-administer medications and medications should not be left at the bedside. Review of policy, Self-Administration reviewed 01/2026, revealed, .It is the policy of this facility to honor residents' rights to self-administer medications if a resident verbalizes that he/she wishes to self-administer medications and the interdisciplinary team (IDT) has determined that this practice is clinically appropriate and safe based on individualized resident assessment. with the intervention .5. A care plan will be initiated for residents who can safely self-administer medications .6. A physician's order will be obtained for residents who can safely self-administer medications .		

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 05/29/2026
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)		
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 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 (continued on next page)		

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 05/29/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. (continued on next page)		

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 05/29/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 05/29/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 reddened 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. 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. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 05/29/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, It (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 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 (continued on next page)		

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 05/29/2026
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)		
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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: 235637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2026
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)		
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete accurate assessments for 1 of 12 residents (Resident#14) reviewed for accurate assessments, resulting in an inaccurate reflection of the resident's status and the potential for impaired medical, functional, and psychosocial problems due to unidentified needs. Findings include: Resident #14: Review of the Face Sheet revealed Resident #14 was a female with pertinent diagnoses which included dementia (progressive brain disease which affects memory, language, problem solving, and thinking severe enough to interfere with daily life) with behavioral disturbance, stroke (blood flow was interrupted or reduced causing brain damage), paralysis, dysphagia (difficulty swallowing), malnutrition, need for assistance for personal care, and speech impairment. Review of Minimum Data Set (MDS) for Resident #14 dated 4/23/26 revealed, she had a BIMS (Brief Mental Status Score) of 14. Review of the MDS for 4/23/26 revealed the assessment had been modified and then corrected. Review of MDS Assessments for Resident #14 revealed, 2/4/26 BIMS score of 3 (severely cognitively impaired); 11/4/25 BIMS score of 11 (moderately cognitively impaired); 9/16/25 BIMS score of 11; and 6/16/25 BIMS score of 9 (moderately cognitively impaired).In an interview on 05/28/2026 at 1:50 PM, Regional MDS Coordinator Y reported she had started on 5/1/26. Regional MDS Coordinator Y reported she had come to the facility to fill in for the MDS Coordinator as the facility did not currently have one as the last MDS Coordinator had left in February 2026. Regional MDS Coordinator Y reported prior to her starting the facility MDS evaluations were being completed by various staff members at the facility. Regional MDS Coordinator Y reported staff were to assess the resident by reviewing information from the medical record and if able to interview the resident. Review of Resident #14's medical record revealed no illness which would affect the outcome of the BIMS assessment dated [DATE]. Review of the MDS 3.0 RAI Manual vl. 16, Chapter 1: Resident Assessment Instrument (RAI), revealed .an accurate assessment requires collecting information from multiple sources, some of which are mandated by regulations . It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT completing the assessment. As such, nursing homes are responsible for ensuring that all participants in the assessment process have the requisite knowledge to complete an accurate assessment .		

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 05/29/2026
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)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow professional standards of practice for medication administration for 1 resident (Resident #29) of 5 residents reviewed for medication administration, resulting in an inhaler (medication that is inhaled) being administered outside of manufacturer recommendations and oral pills being administered without following resident preference for being crushed, and the potential for adverse side effects and choking. Findings include: Review of an admission Record revealed Resident #29 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #29, with a reference date of 4/24/26 revealed a Brief Interview for Mental Status (BIMS) score of 10, out of a total possible score of 15, which indicated Resident #29 was cognitively impaired. During an observation on 05/28/2026 at 7:39 AM in Resident #29's room, Agency-Licensed Practical Nurse (A-LPN) II handed the resident a cup with 11 pills in it. Resident #29 emptied the cup into her mouth and began chewing, then grimacing and ultimately spitting the pills out. A-LPN II gave Resident #29 another cup of water and tried giving the pills to her (Resident #29) again, but the resident just spit them out again and said I can't swallow them. A-LPN II reported that she could try to crush the pills and put them in pudding and Resident #29 agreed. A-LPN II walked out to the medication cart and stated, .it says right here on the sheet that she (Resident #29) takes her pills crushed. A-LPN II crushed the pills and Resident #29 was able to take them with no issue. A-LPN II then handed Resident #29 her inhaler Breyna (steroid inhaler to treat breathing problems) and the resident took 2 puffs. A-LPN II did not offer water and/or encourage Resident #29 to swish and spit. In an interview on 5/28/26 at 7:50 AM, A-LPN II reported that Breyna inhaler was not a steroid and did not require a swish and spit after administration. This surveyor requested that A-LPN II double checked that information. A-LPN II reviewed the label of Breyna and reported that yes, it says to swish and spit after administration to avoid getting thrush (yeast (fungal) infection) in the mouth. During an additional observation on 05/29/2026 at 8:49 AM A-LPN LL was at the medication cart preparing medication for Resident #29. The report sheet on the cart indicated that Resident #29 took her pills crushed. A-LPN LL proceeded to prepare the oral medications and placed 11 pills into a cup and grabbed Resident #29's Breyna inhaler from the medication cart. A-LPN LL did not crush the pills. A-LPN LL entered Resident #29's room, A-LPN LL handed the cup of pills to Resident #29 and the resident put them all in her mouth and tried to swallow them. Resident #29 said, I can't, I can't, then spit the medications out. A-LPN LL picked up the pills and tried to give Resident #29 one pill at a time, but the resident started coughing and spit the pills out again. A-LPN LL explained to Resident #29 that she would have to start all over and she would try crushing the pills this time. At 9:05 AM A-LPN LL handed Resident #29 her Breyna inhaler and the resident took 2 puffs and handed it back to the nurse and took a drink of water. A-LPN LL did not encourage Resident #29 to swish and spit after administration of the inhaler. In an interview on 5/29/26 at 9:08 AM, Resident #29 reported that she had been having trouble swallowing pills and would like them to be crushed. In an interview on 05/29/2026 at 9:12 AM, A-LPN LL reported that her report sheet indicated that Resident #29 took her pills whole and she had not heard anything different. A-LPN LL reported that with Breyna inhaler, it is recommended to swish and spit afterwards and stated, .I think we just do what the resident allows. this is my first time with her. Review of Nursing Report Sheet observed on the medication cart at 9:12 AM indicated crushed next to Resident #29's name. Review of Resident #29's Physician Orders revealed, Budesonide-formoterol (Breyna) HFA aerosol inhaler. 2 puffs inhalation twice a day. Start Date: 4/24/26. Review of Resident #29's Progress Notes dated 5/28/26 revealed, .Takes meds crushed in pudding without difficulty .Review of Resident #29's Progress Note Dated 5/5/29 revealed, .Medications administered crushed in pudding, as clinically appropriate .Review of Breyna Package Insert revealed, .Administration Information: BREYNA should be administered as 2 inhalations twice daily (morning and evening, approximately 12 (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 05/29/2026
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)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours apart), every day by the orally inhaled route only. After inhalation, the patient should rinse the mouth with water without swallowing. Adverse Reactions/Side Effects: .inhaled corticosteroid used may result in the following: Candida albicans infection. In clinical studies, the development of localized infections of the mouth and pharynx with Candida albicans has occurred in patients treated with budesonide and formoterol fumarate dihydrate inhalation aerosol. When such an infection develops, it should be treated with appropriate local or systemic (i.e., oral antifungal) therapy while treatment with BREYNA continues, but at times therapy with BREYNA may need to be interrupted. Advise the patient to rinse his/her mouth with water without swallowing following inhalation to help reduce the risk of oropharyngeal candidiasis. In an interview on 05/29/2026 at 9:25 AM, Director of Nursing (DON) B reported that there was no specific order for crushing pills and that the nurses were expected to review the report sheet for special instructions before they administer medications. DON B reported that when an inhaled steroid is administered the nurse should encourage the resident to swish and spill to avoid getting a mouth infection.		

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 05/29/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to identify pressure ulcers and ensure appropriate treatment interventions were in place for 1 resident (Resident #4) of 1 resident reviewed for pressure ulcers, resulting in Resident #4 developing a Stage 2 pressure ulcer on the left buttock and the potential for overall deterioration in health status. Findings include:Resident #4Review of an admission Record revealed Resident #4 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: seborrheic dermatitis (flaky, itchy, inflamed skin). Resident #4 admitted to the facility with hospice services already in place.Review of a Minimum Data Set (MDS) assessment for Resident #4, with a reference date of 3/24/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #4 was cognitively intact. Review of Resident #4's Functional Abilities revealed that she required substantial/maximal assistance (helper does more than half of the effort) to move her body in bed. Section M Skin Conditions indicated that Resident #4 was at risk for developing pressure injuries and had 0 unhealed pressure injuries. Section E Behaviors indicated that Resident #4 did not refuse care.Review of Resident #4's Braden Scale for Predication of Pressure Sore Risk revealed the following assessments (19 or higher is Not at risk, 15-18 is At risk, 13-14 is Moderate risk, 10-12 is High risk, and 9 or less is Very high risk): 5/25/26 indicated 15 At risk. 4/6/26 indicated 12 High risk. 3/30/26 10 High risk. 3/23/26 11 High Risk. 3/14/26 13 Moderate risk. It was noted that Resident #4's risk for pressure ulcers had decreased since admission. Review of Resident #4's Skin Care Plan revealed, Problem Start Date: 03/13/2026 Category: *Skin Integrity Resident is at risk for impaired skin integrity related to decreased mobility, left above the knee amputation (removed), bed bound, receiving Hospice services.Interventions: .Assist resident with turning and repositioning as needed. Complete skin inspection weekly and as needed. Encourage resident to reposition self if able. Encourage/assist as needed to elevate heels off the mattress as tolerated. Hospice services per orders. Notify nurse of any new areas of skin impairment noted during bathing or daily care (e.g., redness, blisters, bruises, discoloration, impairment related to medical device/tubing). Pressure redistribution mattress to bed . Preventative treatment(s) per orders . Provide a non-irritating surface to reduce friction or shearing forces (when skin drags across a surface). These interventions were created on 3/13/26.Review of Resident #4's Skin Care Plan revealed, Problem Start Date: 04/20/2026 Category: *Skin Integrity Resident has impaired skin integrity related to obesity and incontinence as evidenced by: self-inflicted scratched area on L buttock. Interventions: . Administer treatment(s) per orders. Assist resident with turning and repositioning as needed. Complete skin inspection weekly and as needed. Complete wound evaluation to observe the progress of the resident's skin condition. Encourage resident to reposition self if able. Encourage/assist as needed to elevate heels off the mattress as tolerated. Hospice services per orders. Notify (SPECIFY: Wound Care Company) of any noted worsening skin impairment. Notify Nurse of any new areas of skin impairment noted during bathing or daily care (e.g., redness, blisters, bruises, discoloration, impairment related to medical device/tubing). Notify Physician/NP (nurse practitioner)/PA (physician assistant) of noted worsening skin condition or any new areas of skin impairment. Notify Physician/NP/PA of signs/symptoms of infection (new or change in type/amount/color of drainage, bleeding, foul odor). Palliative services as ordered. Pressure redistribution device in chair. Pressure redistribution mattress to bed . Provide a non-irritating surface to reduce friction or shearing forces. (all of the above interventions were started on 04/20/2026). Provide incontinence care and apply protective barrier cream after each incontinent episode as needed. Start Date: 05/22/2026 air mattress to bed. Start Date: 05/22/2026 specialty cushion to w/c. It was noted that the care plan was nearly identical to the one already in place.In an interview on 5/27/26 at 6:49 AM, Licensed Practical Nurse (LPN) I reported that Resident #4 did not have any wound treatments ordered.During (continued on next page)		

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 05/29/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an observation and interview on 05/27/2026 at 9:09 AM Resident #4 was lying in her bed. Hospice Aide (HA) OO was performing a bed bath. HA OO reported that Resident #4 had a painful wound on her left buttocks and a new blister on her right ischial tuberosity (lower buttock/upper leg). Observed open wound approximately the size of a quarter on Resident #4's left buttock with a red firm area surrounding the wound, and the entire upper buttock area was dark red and non-blanchable (redness caused by prolonged pressure, indicative of underlying tissue damage). Both areas were painful when touched. Resident #4 had 2 open wounds on her left chin that were partially crusted with blood and multiple wounds on her chest that were crusted and/or bleeding. Resident #4 reported that she picked at her skin because it itched. Resident #4 reported that when she needed to use the bedpan, she had to wait a long time to have her call light answered. Review of Resident #4's Current Physician Orders revealed, Apply Skin protectant after each incontinent episode/toileting assistance/brief change. Every shift. Start date 3/13/26." L (left) buttock apply Triad or barrier cream to R (right) buttock, observe for s/s (signs and symptoms) of infection. Every shift. Start date: 4/29/26. In an interview and observation on 05/28/2026 at 6:50 AM, Resident #4 reported that she had been waiting all night for assistance and now she had a bowel movement in her bed. Resident #4 was positioned leaning to her right side, facing the door, with the head of the bed (HOB) approximately 30 degrees and her call light was on. During an observation and interview on 05/28/2026 at 6:57 AM in Resident #4's room, Certified Nursing Assistant (CNA) O answered Resident #4's call light and the resident requested to be cleaned up. CNA O turned Resident #4's call light off, told her that it would be a few minutes because she needed to find another CNA to help and walked out of the room. Resident #4 reported that she needed to have her head elevated but liked to have a pillow behind her back so that she was off her bottom. At 7:04 AM CNA O entered the room to perform incontinence care. CNA O pulled on the pad underneath Resident #4 to drag the resident to the left side of the bed and then positioned the resident onto her right side. Resident #4 did not help with repositioning. There was a small amount of bowel movement in Resident #4's brief and on the pad underneath her. CNA O cleaned Resident #4 with cleanser and dry wipes. Resident #4 complained of pain when CNA O tried to clean the buttocks area. CNA O wiped directly over the wound on Resident #4's left buttock and then with soiled gloves still on, CNA O grabbed a tube of zinc oxide (barrier cream to protect the skin from moisture), squeezed it into her hand, and smeared it all over Resident #4's buttocks, including the open wound on the left buttocks. Resident #4 complained of pain. CNA O finished with care and positioned Resident #4 on her right side, as she was prior to the care. Resident #4 reported that she normally used the bedpan to have a bowel movement because the stool burned when it touched her skin. In an interview on 05/28/2026 at 7:14 AM, CNA PP reported that she had worked third shift and was staying over to cover call ins. CNA PP reported that she had taken care of Resident #4 twice during the night and had documented the resident's bowel movements (BM's). Review of Resident #4's documentation by CNA's during third shift on 5/27/25-5/28/26 revealed no documentation of care or BM's. In a subsequent interview on 05/29/2026 at 2:01 PM, Director of Nursing (DON) B reported that CNA's are expected to document urine and BM's but there was no documentation for third shift on 5/27/26-5/28/26. In an interview on 05/28/2026 at 10:17 AM, Registered Nurse (RN) M reported that she had been filling in as wound nurse for the past couple of months. RN M reported that she went along with the wound provider once a week but was not familiar with wound staging or how to describe the characteristics of a wound. RN M reported that she could not describe what kind of wounds Resident #4 had. RN M reported that the provider saw Resident #4 on 5/27/26 but she (RN M) was only assisting with positioning and did not observe the wounds. In an interview on 05/28/2026 at 10:28 AM to seek clarification of Resident #4's wound locations and staging, DON B reported that left buttock and coccyx (tailbone area) were being used interchangeably for the same wound location in Resident #4's record. DON B reported that she was not sure why the assessments indicate the wound was first identified on 3/13/26 (admission) but that the first formal assessment in the record was on 4/9/26 and prior to that the skin assessments indicated that there were no open areas. DON B was (continued on next page)		

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 05/29/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not aware of a new blister on Resident #4's right ischial tuberosity. DON B reported that Resident #4 currently did not have any open wounds and did not require enhanced barrier precautions (EBP). DON B reported that the wound on Resident #4's left buttock was an abrasion. This surveyor requested an observation of Resident #4's wounds to confirm status and locations. During an observation on 05/28/2026 at 10:52 AM in Resident #4's room, the resident was still positioned on her right side (4 hours). DON B and RN M entered the room and put gloves on. Observed Resident #4's buttocks with a thick coating of white cream covering the entire coccyx/buttock area. The left buttock wound was completely covered with cream, but the redness over the coccyx/buttocks was visible even through the thick cream. DON B touched the left buttock and Resident #4 complained of pain. DON B reported that there was an area of firmness on the left buttock but that she did not see an open wound, it was just an abrasion and the area on the right ischial tuberosity that the hospice aide reported was observed pink and the blister was not visible. Resident #4's left chin wound was covered with ointment but did not have a bandage over it. DON B reported that she still did not feel that Resident #4 was a candidate for EBP. During an observation on 05/28/2026 at 1:09 PM Resident #4 was still lying in bed facing towards the right and her heel was laying flat on the surface of the bed. It was noted that the resident did not have EBP in place. Review of Resident #4's Admissions Assessment dated 3/13/26 at 12:00 PM revealed, .Some redness in skin folds. otherwise skin intact, no active wounds present. Review of Resident #4's Nurse's Note dated 03/31/2026 at 10:57 AM revealed, Patient is A&O x4. Is able to make needs known. Has scabbed over lesions on the right breast and bilateral upper abdomen that are caused by scratching. Has a stage 1 pressure injury on her coccyx area with two small open areas and healing tissue around the wound. This was the first mention of a wound on Resident #4's buttocks/coccyx area. Review of Resident #4's Wound Provider Visit Note dated 4/8/26 revealed, .Reason for visit: new skin and wound consult. Wound assessment: . left buttock. Primary etiology (cause): Shearing (when skin sticks to a surface while underlying bones or deep tissues move), Stage/severity: Full thickness (through all the layers of the skin and into the fat layer), Wound Status: NEW, Size: 2.5 CM x 0.5 cm x 0.1 cm. Wound base: 25-49% slough (white dead tissue) 75-99% granulation (new tissue that fills the base of an open wound as it heals) Exudate (drainage): scant amount of serous (clear or yellow fluid). Assessment: non-pressure chronic ulcer of buttock with fat layer exposed. Treatment Recommendations: 1. Cleanse with normal saline. 2. Apply Triad paste (absorbs moisture and adheres to wet or broken skin) or similar zinc (skin protectant) based barrier cream, to base of the wound. 3. Secure with (sic) leave open to air. 4. Change BID (twice daily) and PRN. Review of Resident #4's Skin Body Assessment dated 5/18/26 completed by licensed nursing staff revealed, .Areas of skin impairment: .Scab to left cheek due to itching and open area to right ischial tuberosity. Review of Resident #4's Wound Provider Visit Note dated 5/20/26 revealed, .pt (patient) with worsening irritation to chin from scratching/picking; continued pain to left buttocks. Physical examination: . Skin rash, ulcers, cluster of red, crusted lesions to left chin/lower lip area, consistent with localized STAPH INFECTION. Wound assessment: .left buttock. worsening. Size: 3.5 cm x 2.5 cm x 0.1 cm. Assessment: non-pressure chronic ulcer of buttock with fat layer exposed, Excoriation (skin picking) disorder, Local infection of the skin and subcutaneous tissue. Treatment Recommendations: 1. Cleanse with soap and water, pat dry. 2. Apply barrier cream, (house supply) to base of the wound. 3. Secure with (sic) leave open to air. 4. Change Q (every) shift and PRN. F/u (follow up) in 1 week; consider transition to hydrocolloid patch to affected area. Review of Resident #4's Progress Note dated 5/21/26 created by DON B revealed, .Resident has excoriation/shearing area on her L (left) buttock that has increased slightly in measurement. Wound NP (nurse practitioner) changed treatment at most recent visit Review of Resident #4's Progress Note dated 5/27/26 revealed, New intact blister reported by hospice aide with bed bath to L (left) posterior buttock near thigh .Review of Resident #4's Wound Provider Visit Note dated 5/27/26 at 8:19 PM revealed, .Skin: history of chronic wound, history of chronic skin condition, rash, history of skin picking on face and other areas. Wound Assessment: .left buttock. Primary etiology: Shearing, Stage/severity: Full (continued on next page)		

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 05/29/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thickness, Size: 1 CM x 0.4 cm x 0.1 cm. Wound base: 50-74% epithelial (light pink shiny new layer of skin), 50-74% granulation Exudate: scant amount of serous: Assessment: non-pressure chronic ulcer of buttock with fat layer exposed, Excoriation disorder, Local infection of the skin and subcutaneous tissue. Treatment Recommendations: 1. Cleanse with soap and water, pat dry. 2. Apply barrier cream, (house supply) to base of the wound. 3. Secure with (sic) leave open to air. 4. Change Q (every) shift and PRN. In a subsequent interview on 05/28/2026 at 3:52 PM, DON B reported that she and Regional Infection Preventionist (R-IP) FF had re-assessed Resident #4's bottom and observed an open wound on the resident's left buttock and have staged the wound as a Stage 2 Pressure Ulcer. DON B reported that they have initiated EBP and changed the wound treatment orders to include a Hydrocolloid dressing (water proof bandage) to be applied over the wound. DON B reported that the facility would be looking for a new wound provider but in the meantime the facility doctor will be overseeing Resident #4's wound treatment. DON B was not aware that Resident #4 had been on an antibiotic for an infection of the wounds on her face. Review of Resident #4's Progress Note Dated 5/28/26 at 4:06 PM revealed, At approximately 11 AM DON, charge/wound nurse and surveyor entered (Resident #4's) room to observe skin on L (left) buttock. At this time the area was charted as abrasion was not visualized as open. The area noted in progress notes as a blister was not visualized as a blister but a small pink blanchable area 0.5 cm x 0.3 cm not open will monitor. Barrier cream was applied to buttock. Area was reassessed with DON and regional nurse at approximately 3:30 PM, resident was turned onto R (right) side, and the L buttock had an open area 1 cm x 0.5 cm x 0.1 cm that was assessed as a Stage 2. The area (sic) awaiting return call from (Physician Assistant) for treatment order. CP (care plan)/profile updated, enhanced barriers initiated, Hospice notified, air mattress in place, dietary interventions in place with monitoring, gel cushion to wheelchair. (Resident #4) is on hospice and at risk for skin breakdown. She chooses to stay in bed and will refuse to get up in wheelchair, she frequently requires her HOB to be elevated for ease of breathing r/t (related to) CHF (congestive heart failure)/COPD (Chronic obstructive pulmonary disease). Staff will continue to assist with turning and repositioning frequently and as resident allows. Unavoidable wound assessment completed for MD (medical doctor) to sign. Review of the facility policies for Staging Classification per National Pressure Injury Advisory Panel dated 6/2019 revealed, Staging Classification per National Pressure Injury Advisory Panel: Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities, and condition of the soft tissue. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARS), or traumatic wounds (skin tears, burns, abrasions). Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 05/29/2026
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)		
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Review of the facility policy Pressure Injury Prevention and Care last reviewed 1/20226 revealed, . 5. Interventions will be implemented, and care planned to prevent pressure injury development or to promote pressure injury resolution. Examples of interventions based on individualized resident needs may include the following. This list is not all-inclusive, nor does it apply to every resident or situation: Pressure reduction cushion to wheelchair. Keep skin clean and dry . Avoid friction or shearing when assisting resident with transfers. Manage incontinence and use moisture barrier. Repositioning of residents; provision of required assistance as allowed and tolerated. Use positioning devices (pillow, blanket, folded sheet, etc.) to prevent skin-on-skin contact when positioning a resident on their side in bed.		

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 05/29/2026
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)		
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: 235637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2026
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)		
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: 235637	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2026
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)		
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)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 05/29/2026
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)		
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.		

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 05/29/2026
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)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain a medication error rate less than 5% in 1 resident (Resident #29) of 5 residents reviewed for medication administration, resulting in the potential for medication adverse effects. The medication error rate was 6.25%. Findings include: Review of an admission Record revealed Resident #29 was originally admitted to the facility on [DATE]. During an observation on 05/28/2026 at 7:39 AM in Resident #29's room, Agency-Licensed Practical Nurse (A-LPN) II handed Resident #29 her inhaler Breyna and the resident took 2 puffs. A-LPN II did not encourage Resident #29 to swish and spit with water following the inhaler. In an interview on 5/28/26 at 7:50 AM, A-LPN II reported that Breyna inhaler was not a steroid and did not require a swish and spit after administration. This surveyor requested that A-LPN II double checked that information. A-LPN II reviewed the label of Breyna and reported that yes, it says to swish and spit after administration to avoid getting thrush (yeast infection) in the mouth. During an additional observation on 05/29/2026 at 9:05 AM in Resident #29's room, A-LPN LL handed Resident #29 her Breyna inhaler and the resident took 2 puffs and handed it back to the nurse and took a drink of her water. A-LPN LL did not encourage Resident #29 to swish and spit after administration of the inhaler. In an interview on 05/29/2026 at 9:12 AM, A-LPN LL reported that with Breyna inhaler, it is recommended to swish and spit afterwards and stated, .I think we just do what the resident allows. this is my first time with her. Review of Resident #29's Physician Orders revealed, Budesonide-formoterol (Breyna) HFA aerosol inhaler. 2 puffs inhalation twice a day. Start Date: 4/24/26. Review of Breyna Package Insert revealed, .Administration Information: BREYNA should be administered as 2 inhalations twice daily (morning and evening, approximately 12 hours apart), every day by the orally inhaled route only. After inhalation, the patient should rinse the mouth with water without swallowing. Adverse Reactions/Side Effects: .inhaled corticosteroid used may result in the following: Candida albicans infection. In clinical studies, the development of localized infections of the mouth and pharynx with Candida albicans has occurred in patients treated with budesonide and formoterol fumarate dihydrate inhalation aerosol. When such an infection develops, it should be treated with appropriate local or systemic (i.e., oral antifungal) therapy while treatment with BREYNA continues, but at times therapy with BREYNA may need to be interrupted. Advise the patient to rinse his/her mouth with water without swallowing following inhalation to help reduce the risk of oropharyngeal (mouth & throat) candidiasis (yeast infection). In an interview on 05/29/2026 at 9:25 AM, Director of Nursing (DON) B reported that when an inhaled steroid is administered the nurse should encourage the resident to swish and spill to avoid getting a mouth infection. Review of Fundamentals of Nursing ([NAME] and [NAME]) revealed, Professional standards such as Nursing: Scope and Standards of Practice (ANA, 2010) .apply to the activity of medication administration. To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these six rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 39307-39313). Elsevier Health Sciences. Kindle Edition.		

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 05/29/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to effectively implement Enhanced Barrier Precautions (EBP) and maintain infection control standards during incontinence (involuntary leakage of urine and feces) care per Centers for Disease Control and Prevention (CDC) guidance, in 2 residents (Resident #39 & #4) from a total sample of 20 residents, resulting in the potential for cross-contamination and the development and spread of infection to a vulnerable population. Findings include: Resident #39 Review of an admission Record revealed Resident #39 was originally admitted to the facility on [DATE]. During an observation on 05/27/2026 at 6:40 AM in Resident #39's room, the resident was observed lying in bed and a bag with urine was observed hanging on the bed frame. There was no signage indicating that Resident #39 had EBP in place. During an observation on 05/27/2026 at 8:17 AM in Resident #39's room, Certified Nursing Assistant (CNA) R entered the room to assist the resident with care. CNA R entered the room and was not wearing a gown. CNA R put gloves on and used disposable wipes to clean Resident #39's bottom after he had a bowel movement (BM). There was no signage indicating that Resident #39 had EBP in place. Review of Resident #39's Progress Notes dated 5/26/26 at 3:05 PM revealed, Resident arrived to facility via EMS (emergency medical services) at approximately 1:00 PM. Resident has a patent foley cath (catheter) (tube inserted through urethra into the bladder to drain urine), urine yellow. incontinent of bowel. Review of Resident #39's Physician Orders revealed, Catheter Care every shift. Start Date: 5/26/26. During an observation on 05/27/2026 at 9:31 AM, Director of Nursing (DON) B placed a sign indicating EBP on Resident #39's door and placed a cart with gowns, gloves, and masks in the hall outside of the resident's room. In an interview on 5/29/26 at 3:52 PM, DON B reported that Resident #39 should have been placed on EBP upon admission due to having an indwelling device. Resident #4 Review of an admission Record revealed Resident #4 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: seborrheic dermatitis (flaky, itchy, inflamed skin). Review of Resident #4's Skin Care Plan revealed, Problem Start Date: 04/20/2026 Category: *Skin Integrity Resident has impaired skin integrity related to obesity and incontinence as evidenced by: self-inflicted scratched area on L buttock. Review of Resident #4's Behavior Care Plan revealed, Problem Start Date: 05/08/2026 Category: *Behaviors Resident has behavior(s): aggressively scratching skin and picking at skin causing injury/open areas. Interventions: .Approach Start Date: 05/08/2026 Attempt to redirect resident when exhibiting behaviors by reminding her she is picking at her skin; re-approach when resident has de-escalated. During an observation and interview on 05/27/2026 at 9:09 AM Resident #4 was lying in her bed. There was no indication that Resident #4 had EBP in place. Hospice Aide (HA) OO was performing a bed bath, wearing gloves and no gown. HA OO reported that Resident #4 had a painful wound on her left buttocks and a new blister on her right lower buttock crease. Observed open wound approximately the size of a quarter on Resident #4's left buttock with a red firm area surrounding the wound, and the entire upper buttock area was dark red and non-blanchable (redness caused by prolonged pressure, indicative of underlying tissue damage). Both areas were painful when touched. Resident #4 had 2 open wounds on her left chin that were partially crusted with blood and multiple wounds on her chest that were crusted and/or bleeding. Resident #4 reported that she picked at her skin because it itched. Review of Resident #4's Current Physician Orders revealed, 1. Mupirocin Calcium Cream 2 % (topical antibiotic), apply to facial lesions BID (twice daily) for 7 days then BID PRN (as needed) for recurrence. Start Date: 5/20/26. 2. Chin/lower face areas: monitor for signs/symptoms of infection Q (every) shift until healed. Start Date: 5/8/26. 3. L (left) buttock apply Triad (skin protectant cream) or barrier cream to R (right) buttock, observe for s/s (signs and symptoms) of infection. Every shift. Start date: 4/29/26. 5. Skin prep to L chest area daily and PRN. Start date: 5/20/26. During an observation and interview on 05/28/2026 at 6:57 AM in Resident #4's room, Certified Nursing Assistant (CNA) O answered Resident (continued on next page)		

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 05/29/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#4's call light and the resident requested to be cleaned up. There was no signage indicating that Resident #4 had EBP in place. At 7:04 AM CNA O entered the room to perform incontinence care. CNA O put gloves on but did not put a gown on. There was a small amount of bowel movement in Resident #4's brief and on the pad underneath her. CNA O cleaned Resident #4 with cleanser and dry wipes. Resident #4 complained of pain when CNA O tried to clean the buttocks area. CNA O wiped directly over the wound on Resident #4's left buttock and then with soiled gloves still on, CNA O grabbed a tube of zinc oxide (barrier cream to protect the skin from moisture), squeezed it into her hand, and smeared it all over Resident #4's buttocks, including the open wound on the left buttocks. Resident #4 complained of pain. CNA O finished with care and positioned Resident #4 on her right side, as she was prior to the care. CNA O did not change her gloves after they were soiled and prior to applying barrier cream to an open wound. In an interview on 05/28/2026 at 10:28 AM, DON B reported that Resident #4 currently did not have any open wounds and did not require enhanced barrier precautions (EBP). DON B reported that the wound on Resident #4's left buttock was an abrasion and the wounds on Resident #4's chin and chest were caused by scratching and just recently started. This surveyor requested an observation of Resident #4's wounds to confirm status and locations. During an observation on 05/28/2026 at 10:52 AM in Resident #4's room, DON B and Registered Nurse (RN) M entered the room and donned gloves. Observed Resident #4's buttocks with a thick coating of white cream covering the entire coccyx/buttock area. The left buttock wound was completely covered with cream, but the redness over the coccyx/buttocks was visible even through the thick cream. DON B touched the left buttock and Resident #4 complained of pain. DON B reported that there was an area of firmness on the left buttock but that she did not see an open wound, it was just an abrasion. Resident #4's left chin wound was covered with ointment but did not have a bandage over it. DON B reported that she still did not feel that Resident #4 was a candidate for EBP. Review of Resident #4's Wound Provider Visit Note dated 4/8/26 revealed, . Reason for visit: new skin and wound consult. Wound assessment: . left buttock. Stage/severity: Full thickness (through all the layers of the skin and into the fat layer), Wound Status: NEW, Size: 2.5 CM x 0.5 cm x 0.1 cm. Wound base: 25-49% slough (white dead tissue) 75-99% granulation (new tissue that fills the base of an open wound as it heals) Exudate (drainage): scant amount of serous (clear or yellow fluid). Review of Resident #4's Wound Provider Visit Note dated 5/20/26 revealed, . pt (patient) with worsening irritation to chin from scratching/picking; continued pain to left buttocks. Physical examination: . Skin rash, ulcers, cluster of red, crusted lesions to left chin/lower lip area, consistent with localized STAPH INFECTION (bacterial infection). Wound assessment: .left buttock.worsening. Size: 3.5 cm x 2.5 cm x0.1 cm. Assessment: non-pressure chronic ulcer of buttock with fat layer exposed, Excoriation (skin picking) disorder, Local infection of the skin and subcutaneous tissue. Review of Resident #4's Progress Note dated 5/21/26 created by DON B revealed, .Resident has excoriation/shearing area on her L (left) buttock that has increased slightly in measurement. Wound NP (nurse practitioner) changed treatment at most recent visit Review of Resident #4's Wound Provider Visit Note dated 5/27/26 at 8:19 PM revealed, .Skin: history of chronic wound, history of chronic skin condition, rash, history of skin picking on face and other areas. Wound Assessment: .left buttock. Stage/severity: Full thickness, Size: 1 CM x 0.4 cm x 0.1 cm. Wound base: 50-74% epithelial (light pink shiny new layer of skin), 50-74% granulation Exudate: scant amount of serous: Assessment: non-pressure chronic ulcer of buttock with fat layer exposed, Excoriation disorder, Local infection of the skin and subcutaneous tissue. In a subsequent interview on 05/28/2026 at 3:52 PM, DON B reported that she and Regional Infection Preventionist (R-IP) FF had re-assessed Resident #4's bottom and observed an open wound on the resident's left buttock and have staged the wound as a Stage 2 Pressure Ulcer. DON B reported that they have initiated EBP and changed the wound treatment orders to include a Hydrocolloid dressing (water proof bandage) to be applied over the wound. DON B reported that the facility would be looking for a new wound provider but in the meantime the facility doctor will be overseeing Resident #4's wound treatment. DON B was not aware that Resident #4 had been on an antibiotic for an infection of the wounds on her (continued on next page)		

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 05/29/2026
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)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	face.Review of Resident #4's Progress Note Dated 5/28/26 at 4:06 PM revealed, .resident was turned onto R (right) side, and the L buttock had an open area 1 cm x 0.5 cm x 0.1 cm that was assessed as a Stage 2. enhanced barriers initiated.Review of CDC guidance at www.cdc.gov/long-term-care-facilities, Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes revealed, .13. If a resident does not have a history of a MDRO (multidrug-resistant organism) but does have an indwelling medical device or wound, should they still be placed on Enhanced Barrier Precautions? Yes. Enhanced Barrier Precautions are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for Contact Precautions, even if they have no history of MDRO colonization or infection and regardless of whether others in the facility are known to have MDRO colonization (when the bacteria lives in or on the body without making you sick or causing symptoms). This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized. 14. Why did CDC expand Enhanced Barrier Precautions to include all residents with wounds or indwelling medical devices, regardless of MDRO status? Indwelling medical devices and wounds are risk factors for colonization with a MDRO. Once colonized, these residents can serve as sources of transmission within the facility. The expansion of EBP for all residents with wounds or indwelling medical devices is intended to protect these high-risk individuals both from acquisition and from serving as a source of transmission if they have already become colonized .23. The guidance describes that all residents with wounds would meet the criteria for Enhanced Barrier Precautions. What is the definition of a wound in relation to this guidance? In the guidance, wound care is included as a high-contact resident care activity and is generally defined as the care of any skin opening requiring a dressing. However, the intent of Enhanced Barrier Precautions is to focus on residents with a higher risk of acquiring an MDRO over a prolonged period of time. This generally includes residents with chronic wounds, and not those with only shorter-lasting wounds, such as skin breaks or skin tears covered with a Band-aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, and chronic venous stasis ulcers . Reviewed of Implementing the Use of Enhanced Barrier Precautions in Skilled Long-Term Care Nursing Facilities by APIC dated 2024 revealed, .What is considered a chronic wound? The longer a wound is present, the more concern we have for those wounds becoming colonized with an MDRO. Chronic wounds are often poorly healing wounds or areas of the skin in residents with underlying medical conditions, resulting in pressure areas, diabetic ulcers, and venous or arterial stasis wounds .Review of the Centers for Disease Control website (https://www.cdc.gov/handhygiene/providers/index.html) last revised on June 25, 2018 revealed, When to Perform Hand Hygiene .before and after having direct contact with a patient ' s intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed) .After contact with blood, body fluids or excretions, mucous membranes, non-intact skin, or wound dressings .After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient .If hands will be moving from a contaminated body site to a clean body site during patient care . Steps for Glove Use .Change gloves during patient care if the hands will move from a contaminated body-site (e.g., perineal area) to a clean body-site (e.g., face) .Remove gloves after contact with a patient and/or the surrounding environment (including medical equipment) using proper technique to prevent hand contamination. Failure to remove gloves after caring for a patient may lead to the spread of potentially deadly germs from one patient to another.		