STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235637	A. Building B. Wing	09/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Plainwell Pines Nursing and Rehabilitation Communi	3260 East B Ave Plainwell, MI 49080

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - 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** 46999 This citation is linked to intake # MI00145717 Based on interview and record review the facility failed to provide an environment free from abuse in 3 residents (Resident #100, Resident #101, and Resident #102) of 5 residents reviewed for abuse, resulting residents experiencing fear, avoidable pain, bruising, and a potential for more serious injury. Findings include: Resident #100 Review of an Admission Record revealed Resident #100, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia, cellulitis of right lower limb, major depressive disorders, generalized anxiety disorder, chronic pain syndrome and bursitis of the right knee (painful swelling of the fluid-filled pads that act as a cushion at the joints). Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 6/03/24 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #100 was moderately cognitively impaired. Review of a Care Plan for Resident #100, with a reference date of 8/9/2021, revealed a problem/goal/approaches of: Problem: I have self-care deficit r/t (related to) dx (diagnosis) of .pain .Goal: (Resident #100) will be clean .and will participate in cares to her fullest ability. Approaches: .do not rush (Resident #100). Allow her to perform .as able .observe for presence of pain . Review of an Incident Investigation Report with a reference date of 7/1/24 revealed: Investigation: (Resident #100) stated CNA P (certified nursing assistant) that provided cares for her overnight (6/30/24) was rough . the CNA was holding her foot up, and then just let her foot drop on the bed. The resident told (CNA) that hurt, the CNA responded and told the resident not to say anything . (Resident #100) went on to state she did not feel safe when she is being changed by CNA P .felt she was going to push her off the bed. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/30/24 at 10:57am, Resident #100 reported she felt Certified Nursing Assistant (CNA) P was abusive to her when she provided cares. Resident #100 reported CNA P was rough during cares, would not allow her to move her own leg despite being told it was painful when staff did it, and dropped her right leg from a height of about 1' which caused her significant pain when her leg hit the mattress. Resident #100 reported she cried after her leg hit the mattress because of the level of pain and that CNA P's actions made her feel worthless. Resident #100 stated I came here for care, not to be beat up. I had to rely on her to help me and I associated her with being mean and cruel. In an interview on 8/30/24, at 3:18pm, Certified Nursing Assistant (CNA) O reported she witnessed CNA P providing cares to Resident #100 in a rough manner on 6/29/24. CNA O reported Resident #100 kept telling CNA P her right leg was very sore and to slow down, but CNA P wasn't listening and just continued to move Resident #100's leg anyway. CNA O reported Resident #100 stated Ow! and CNA O told CNA P that staff were supposed to allow the resident to move her leg on her own to avoid causing her avoidable pain, but CNA P continued to move the resident's leg anyway. CNA O reported she felt very uncomfortable observing how CNA P cared for Resident #100. In an interview on 8/30/24 at 3:28pm, Certified Nursing Assistant (CNA) M reported Resident #100's legs were very sensitive, and it was important to allow her to move her own legs or only assist with them when the resident asked. CNA M reported staff needed to be extremely gentle with cares and never let the resident's legs drop because it was very painful for the resident. In an interview on 9/04/24 at 2:40pm, Director of Nursing (DON) B reported Resident #100 told her she was fearful when CNA P provided cares for her, felt she was too forceful and rough and that she might be pushed off the bed. DON B reported the resident also complained that CNA P intentionally dropped her leg onto the mattress even after being told of the resident's pain. DON B reported Resident #100 did not experience significant pain during cares when cared for properly. Review of a Progress Note dated 7/2/24 revealed: Diagnosis, Assessment and Plan: Pain in right knee. Patient has increased pain in right knee, but she has not gotten her pain medications yet this a.m. Review of a Nursing Progress Note dated 7/1/24 at 8:10am revealed spoke with (Resident #100) r/t (related to) her pain. Pain is mostly in BLE (bilateral lower extremities) and is worse with movement. Pain is frequent (sic) at a level of 7 on a 1-10 scale. Review of Nursing Progress Note dated 7/1/24 at 4:50pm revealed Resident spent the day in her bed today, due to her leg and hip bothering her. Resident #101 Review of an Admission Record revealed Resident #101, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: wedge compression fracture of T11-T12 vertebra (chest region spinal fracture caused by collapse of the vertebra), adult failure to thrive, mood disorder due to known physiological condition, depression related to dementia, spinal stenosis (narrowing of the space between the vertebra which may cause pain, numbness, tingling) spondylolisthesis(condition in which the vertebra slip forward and rest on the vertebra below), and chronic pain syndrome. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 7/05/24 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #101 was cognitively intact. Review of a Care Plan for Resident # 101, with a reference date of 2/16/24, revealed a problem/goal/approaches of: Problem: self-care (sic)deficit r/t (related to) chronic pain .Goal: Resident will be clean .and will participate in cares to their fullest ability. Approaches: Do not rush resident .involve resident in care and decision making .offer choice . In an interview on 8/30/24, at 11:13am, Resident #101 reported Certified Nursing Assistant (CNA) P picked me up and threw me in bed and said, Go to sleep!. Resident #101 reported CNA P did not give him the chance to assist with moving from his bed to his wheelchair or explain what they were going to do. When further queried about the transfer, Resident #101 stated she threw me hard, with force. Resident #101 reported during the forceful transfer from his wheelchair to his bed, his right hand banged against the arm of the wheelchair and caused a large bruise. Resident #101 reported after that incident, which happened in late June 2024, he decided he'd had enough and reported the mistreatment. Resident #101 stated She was abusive, and I've been through enough in my life without someone treating me like that. Resident #101 reported he felt angry, frustrated, and vulnerable as the result of the way CNA P treated him. In an interview on 9/4/24 at 1:49pm, former Nursing Home Administrator (NHA) L reported he interviewed Resident #101 on 7/1/24. NHA L reported during the interview Resident #101 reported CNA P handled him roughly on 6/30/24, grabbed him by the arm and threw him into bed, then told him to go to sleep. NHA L reported Resident #101's hand was bruised because it hit the arm of the wheelchair during the transfer. NHA L reported during the interview, Resident #101 also reported after he was in bed, the CNA abruptly pulled his blanket up, checked his brief, bumped his genitals in the process and when he complained it hurt, CNA P stated you'd better not tell anyone. NHA L reported Resident #101 appeared angered and frustrated by the situation and had a bruise on his right hand. When further queried, NHA L reported following his investigation, he felt the actions of CNA P were abusive. In an interview on 9/4/24 at 2:40pm, Director of Nursing (DON) B reported on 7/1/24, she observed a 4cm x3cm fresh bruise on Resident #101's right hand, between his thumb and index finger. DON B reported the injury was consistent with the resident's hand being caught on the arm of a wheelchair during a transfer, and Resident #101 reported her the injury occurred during a rough transfer performed by CNA P. Resident #102 Review of an Admission Record revealed Resident #102, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified intellectual disabilities, bilateral primary osteoarthritis of knee, anxiety disorder, other reduced mobility and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 6/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #102 was moderately cognitively impaired. Section GG of the MDS revealed Resident #102 required moderate assistance (helper does less than half the effort) to safely transfer to the toilet, and to complete toilet hygiene (perineal hygiene). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Care Plan for Resident #102, with a reference date of 4/22/24, revealed a problem/goal/approaches of: Problem: Resident has care deficits and requires assistance with ADL's (activities of daily living). Goal: Resident care needs will be met .Approaches: Resident is at risk for skin breakdown .Resident is high risk for falls .Resident is incontinent .needs to be checked and changed frequently .resident requires 1 person assistance with a gait belt for transfers . Review of an Investigation Summary with a reference date of 7/1/24 revealed Resident #102 reported the Director of Nursing (DON) B that the nightshift nursing assistant told her to go potty by yourself and turned the light off on the resident while she was in the restroom. In an interview on 9/4/24, at 10:41am, Licensed Practical Nurse (LPN) H reported on the morning of 7/1/24, Resident #102 told her CNA P was mean to her the night before. LPN H reported Resident #102 reported CNA P told her to take herself to the bathroom, stated I'm not helping you, and then turned the bathroom light off and left the resident sitting in the dark. LPN H described Resident #102 as sad and mad about the situation. LPN H reported she was very close to Resident #102 and felt the resident confided in her because she trusted her. When further queried, LPN H reported Resident #102 could not safely take herself to the bathroom or complete her own toilet hygiene and staff should always assist her. In an interview on 9/4/24 at 11:25am, Resident #102 made tangential comments, but could not answer specific questions about the incident involving CNA P on 6/30/24. In an interview on 9/4/24 at 1:05pm, Resident #102's legal guardian (LG) K, reported they were informed of CNA P's comments and actions toward Resident #102. LG K described CNA P's actions/comments as cruel and inappropriate. LG K reported feelings of frustration, helplessness, sadness, and anger would be expected for any reasonable person that was treated in that way. Applying the reasonable person concept, though Resident #102 did not express her feelings and thoughts several weeks later, she was clearly emotionally upset by the comments and actions CNA P directed toward her while caring for her on 6/30-7/1/24. Surveyor attempted to contact CNA P prior to survey exit. No return call prior to exit.