STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235335	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER: Gladwin Nursing and Rehabilitation Community		STREET ADDRESS, CITY, STATE, ZIP CODE: 3270 Pratt Lake Rd Gladwin, MI 48624	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 This citation pertains to intake # MI00148940 Based on interview and record review, the facility failed to initiate an investigation into an allegation of an injury of unknown origin for one of three residents (Resident #1) reviewed. Findings: Resident #1 (R1) Review of a Face Sheet revealed R1 was an [AGE] year old female, admitted to the facility on [DATE] by Hospice for a two day respite stay, with pertinent diagnoses of Alzheimer's and Parkinson's. During an interview on 12/17/24 at 11:54 AM, the complainant/R1's DPOA (durable power of attorney) A stated that R1 was at the facility for two nights starting 12/6/24, and returned home on 12/8/24 with a swollen lip and bruising that R1 did not have prior to going to the facility. The complainant/R1's DPOA Aalso stated (a) that hospice was contacted the evening of 12/8/24 and a hospice nurse was sent to the home to assess the injuries that evening and (b) the facility was called and made aware of the concerns related to the injury of unknown origin. Review of a Hospice Encounter Note dated 12/08/24 at 9:06 PM revealed: PRN (as needed) visit for report of unaccounted bruising to right forearm and swelling to right lower lip. Patient (R1) noted to have swelling to right medial (middle) quarter of lower lip .no documentation of falls in chart or per facility staff. R1 did answer affirmative to the question of if she had fallen but unable to account for details. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235335	A. Building B. Wing	12/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gladwin Nursing and Rehabilitation Community	3270 Pratt Lake Rd Gladwin, MI 48624

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Hospice Encounter Note dated 12/09/24 at 1:30 PM revealed: (Hospice) Nurse asked to assess patients (R1) face and arm where the wounds were after patient (R1) being at (facility name) .Patient (R1) had a fat lip on the mouth, some bruising to the left side of the face and all up and down the right arm. (Complainant/DPOA A) had called the facility on 12/08/24 and spoke with (Medical Records Manager) MRM D who stated she would relay the concerns to the manager and social worker .(Complainant/DPOA A) told the hospice worker that the facility had not called her back .Hospice Social Worker (HSW) B reached out to the facility on [DATE] and was told there were no noted fall or injuries concerning R1 per facility records . hospice had tried contacting the facility many times without good report or response in phone calls and this has become an issue .patient (R1) not able to voice for sure what happened at the facility, (R1) has stories on if it was a fall or from being moved in the bed and is not going to be a good historian for this type of questions .(R1) has been having a harder time with ambulating and transfers since coming home from the facility. During an interview on 12/18/24 at MRM D stated that she may have heard something about R1 falling at the facility but could not recall for sure. MRM D acknowledged speaking with Complainant/DPOA A on 12/08/24 after R1 returned home. MRM D stated that the concerns were sent to the Administrator (ADM) and told Complainant/DPOA A that the Administrator would follow up with her tomorrow (12/09/24). During an interview on 12/18/24 at 12:30 PM, the Administrator stated that he did not call back R1's DPOA on 12/09/24, rather asked Social Worker (SW) E to handle it. The ADM also stated that an investigation into the allegation of an injury of unknown origin was not initiated. During an interview on 12/18/24 at 12:45 PM, Social Worker (SW) E stated that (a) she received a telephone call from HSW B on 12/09/24 about concerns regarding R1's care at the facility, and (b) then spoke with the Director of Nursing (DON) on 12/09/24, and the DON stated that R1 had not fallen at the facility. During an interview on 12/18/24 at 11:35 AM, the DON stated they following: (a) she was asked by SW E if R1 had sustained a fall or injuries while at the facility from 12/06/24 to 12/08/24, (b) she advised SW E that R1 had not fallen or sustained injuries while at the facility, (c) the DON did not interview any staff persons who worked 12/06/24 through 12/08/24, and (e) the DON did not initiate an investigation into an allegation of an injury of unknown origin. Review of the facility Abuse prevention Program Policy & Procedure reflected: (a) Injuries of unknown source-An injury will be classified as an injury of unknown source when the following criteria is met: (1) the source of the injury was not observed by any person, and (2) the source of the injury could not be explained by the resident, and (3) The injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one particular point in time. Review of the facility policy Abuse Prevention Program 7 Components reflected: INVESTIGATION- The Administrator and or Director of Nursing are to initiate and coordinate completion of a thorough investigation. Investigations must be initiated immediately and concluded as soon as possible not to exceed (5) days.