

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 04/17/2025
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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101</p> <p>This citation pertains to intake # MI00151153</p> <p>Based on interview and record review, the facility failed to report a resident-to-resident physical assault to local law enforcement and a second-degree burn sustained from an avoidable hot liquid spill for 2 residents (R1 and R2) out of 4 residents reviewed for abuse and neglect.</p> <p>Findings included:</p> <p>Review of the facility abuse policy dated reviewed 1/2025 revealed, Possible Indicators of Physical Abuse Includes but not limited to Burns, blisters or scalds on hands or torso. Facial injuries ., failure of staff to implement resident interventions, when residents have been assessed and interventions are care planned, failure to monitor, provide adequate supervision to ensure environmental hazards are not present including but not limited to: a. Access to hot water of sufficient temperature to cause tissue injury Reporting/Response. All alleged or suspected violations are reported immediately to the Administrator or Director of Nursing, which are responsible to notify required officials, including to the State Survey Agency, Adult Protective Services, Local Public Safety, Licensure Boards, Regional Director of Operations or Regional Clinical Directors (representative of governing board) and any other agencies in accordance with State law through established procedures. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involved abuse or result in serious bodily injury. Not later than 24 hours if the event that cause the allegation do not involve abuse and does not result in serious bodily injury .j. Begin investigation of the allegation. Procedure. 1. When staff (staff here refers to covered individuals) suspect a crime has occurred against a resident at the facility, they must report the incident to SSA (State Survey Agency) and local law enforcement. 2. Staff must report a suspicion of a crime to the state survey agency, SSA (State Survey Agency) and at least one local law enforcement entity within a designated time frame by e-mail, fax or telephone. The individual does not need to determine which local law enforcement entity. This will meet the individual's obligation to report.</p> <p>R2 (Resident-to-Resident Assault Incident)</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R2's face sheet no date revealed, he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Autistic disorder (neurodevelopmental disorder characterized by repetitive, restricted and inflexible patterns of behavior, interest and activities as well as difficulties in social interaction and social communication), falls and weakness.</p> <p>Review of the facility reported incident dated 3/1/25 at 4:30 AM revealed the Nursing Home Administrator (NHA) notified the State Survey Agency (SSA) of an incident between R1 and R2 that occurred on 3/1/25 at 4:30 AM where R1 was observed hitting his roommate R2 with his water mug while R2 was still in bed. R2 sustained cuts and bruises to his face. R2 was sent to the emergency room for evaluation and treatment. R1 said was upset that his wife was not in the bed and a stranger was in the bed and that's why he was hitting him. The report revealed both R1 and R2 were both severely mentally impaired. The report did not indicate that the police were notified of this incident.</p> <p>Review of R2's progress note dated 3/1/25 at 5:17 AM revealed, At 0431, nurse heard R2 yelling to knock it off and went into bedroom to find R2 sitting up in bed, and his roommate (R1) hitting him with a water mug. Roommate pulled away immediately, who stated that he was trying to kill him because he was in his wife's spot. Attempted to reorientate roommate with no success. R2 has 2 lacerations on his left eye, red spot on his cheek bone, and a scratch on his chest along with a reddened area on left upper chest. Cleaned laceration and sent to name of emergency room for evaluation. Emergency contact called and notified along with provider and NHA (Nursing Home Administrator). Upon return R2 was moved to (room number).</p> <p>Review of R2's progress note dated 3/1/25 at 6:17 AM revealed, Per NHA not necessary to call police regarding incident.</p> <p>Review of R2's progress note date 3/13/25 at 3:13 PM revealed, name of R2 's family member had told him about the incident from this weekend involving R2 and he was concerned about if it got reported to anyone (i. e. the police, etc.). I explained that we reported the incident to the state immediately and they do an investigation. I explained where things stand with the investigation, and we do not believe that we could have prevented this unfortunately.</p> <p>Review of R2's progress note dated 3/14/25 at 4:42 PM revealed he was discharged to an assisted living facility.</p> <p>R1 (2nd Degree Hot Liquid Injury)</p> <p>A second-degree burn damages the full thickness of the skin causing redness, swelling, blisters and intense pain.</p> <p>Review of R1's face sheet, no date, revealed he was [AGE] years old, admitted on [DATE]. He was on hospice. He had diagnoses that included dementia, metabolic encephalopathy (brain disorder causing brain dysfunction), burn of second degree of right thigh, diabetes mellitus type 2, and falls.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R1's progress note dated 3/25/25 at 8:35 PM revealed, At approximately 4:30 PM, ADON (Assistant Director of Nursing) got a cup of coffee for R1 from the kitchen. Coffee was poured from a less than half full pot and added 2 creams and 1 sweetener. Lid was placed on coffee cup and given to R1. Another resident wanted coffee so this nurse went to get a coffee for the other resident. When this nurse came out of the kitchen R1 was in the center of the dining room and coffee cup was on the floor. CNA (Certified Nurse Aide) changed R1, area on inner thigh was pink, she put cold washcloths on area. His nurse came in his room, seen it, notified (name of doctor) and was awaiting orders. 2030 (9:30 PM) returns to bed, tx (treatment) to heel completed, res (resident) with no c/o (complaint of) thigh areas/burn from earlier in day.</p> <p>Review of R1's altered skin integrity care plan dated 3/13/25 revealed, resident acquired altered skin integrity to right inner thigh-hot liquid spill. Approaches included 4/16/25 Resident, Family educated on risk benefit of regulated temperature to hot liquids & foods. Temps do not exceed 120 degrees.</p> <p>Review of R1's Wound Information Observation History dated 4/7/25 at 3:50 PM revealed the current Director of Nursing (DON) documented, Burn type Partial thickness: redness, blistered, moist, painful, 2 areas of blisters, open measuring 3 cm X 6x6 cm.</p> <p>Review of a Wound Management note for R1, Most Recent Documentation dated 4/17/25 at 11:15 AM, revealed, the wound was identified on 3/25/25 at 5:00 PM and measured 3.6 cm x 6.1 cm.</p> <p>During an interview with the Director of Nursing (DON) on 4/16/25 at 10:37 AM. The DON did not have any incident or accident reports for R1's thigh burn that occurred on 3/25/25. The DON said she started on 4/7/25 and became aware of the burn and started education and a plan of correction. The DON said R1's burn was not reported to the State and that she was not working in the facility at the time of the burn. The DON was not aware why the facility did not report the burn. The DON was asked if the facility reported the physical altercation between R1 and R2 on 3/1/25 at 4:30 am to the police. The DON reviewed the facility investigation and could not locate any police notification. The DON said she was not working in the facility at that time and if she was, she would have reported this event to the police and confirmed that the facility policy would be to report the incident.</p> <p>During a telephone interview with the Nursing Home Administrator (NHA) on 4/16/25 at 10:03 AM, the NHA confirmed that he was aware R1 had sustained a burn when he spilled hot coffee on himself on 3/25/25. The NHA said he was not aware of the extent of injury and the time. When he returned from his vacation, he was aware of the severity of burn, and he did not report it to the State Agency, and he should have reported the burn. The NHA was asked if he reported physically altercation between R1 and R2 on 3/1/25 at 4:30 am to the police. The NHA said he did not report the incident due to the mental condition of the residents. The NHA was asked if the Criminal Justice Act or the facility policy gave exception to reporting to the police based on mental capacity he said, no. The NHA confirmed that physical assault with an object resulting in injury was suspicious of a crime.</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101</p> <p>This citation pertains to intake #MI00151153</p> <p>Based on observations, interviews and record review, the facility a failed to implement their hot liquid policy, accurately assess and implement a safe hot liquid program for 1 Resident (R1) of four residents reviewed, resulting in a second-degree burn caused by a hot liquid.</p> <p>Findings included:</p> <p>A second-degree burn damages the full thickness of the skin causing redness, swelling, blisters and intense pain.</p> <p>Review of R1's face sheet, no date, revealed he was [AGE] years old, admitted on [DATE]. He was on hospice. He had diagnoses that included dementia, metabolic encephalopathy (brain disorder causing brain dysfunction), diabetes mellitus type 2, and falls.</p> <p>Review of the facility Hot/Liquid Food Management policy dated 5/2019 and reviewed 1/2025 revealed, 4. Residents identified through the assessment process as at risk for injury related to exposure to hot liquids shall not be left unsupervised during meal service while pending completion of evaluation.</p> <p>Review of R1's admission Hot Food/Liquid assessment dated [DATE] revealed, yes, resident had poor hand control, yes, moderate to severe vision impairment, no, dementia, no, impulsive acts/short tempered or behavior concerns, he was not dependent feeding himself. The section under the assessment revealed, If any of the questions above are answered with a Yes, STOP! The resident is considered to be high risk for possible management of hot foods or fluids that could place them at risk for injury. The only box marked below this section was to have a cup with a lid. No other safety recommendations were made.</p> <p>Review of R1's progress note dated 3/25/25 at 2:39 PM revealed, R1 has been great during the day. He is friendly and talkative He has been in the dining room spending time with his daughter and wife. He as continued 1:1 from about the hours of 5p -9p. Nursing reports once he is in bed for the evening he does well. He has not been agitated or aggressive towards any residents. He only acts out when staff attempt to redirect him when exit seeking.</p> <p>Review of R1's progress note dated 3/25/25 at 8:35 PM revealed, At approximately 4:30 PM, ADON (Assistant Director of Nursing) got a cup of coffee for R1 from the kitchen. Coffee was poured from a less than half full pot and added 2 creams and 1 sweetener. Lid was placed on coffee cup and given to R1. Another resident wanted coffee so this nurse went to get a coffee for the other resident. When this nurse came out of the kitchen R1 was in the center of the dining room and coffee cup was on the floor. CNA (Certified Nurse Aide) changed R1, area on inner thigh was pink, she put cold washcloths on area. His nurse came in his room, seen it, notified (name of doctor) and was awaiting orders. 2030 (9:30 PM) returns to bed, tx (treatment) to heel completed, res (resident) with no c/o (complaint of) thigh areas/burn from earlier in day.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R1's progress note dated 3/26/25 at 5:46 AM revealed, No c/o (complaint of) pain to upper thigh area, Topical Silvadene (burn medication applied to the skin) applied just before shift change by previous nurse. No evidence of a wound assessment or additional treatment orders were in R1's medical record.</p> <p>Review of R1's Wound Information Observation History dated 4/7/25 at 3:50 PM revealed the current Director of Nursing (DON) documented, Burn type Partial thickness: redness, blistered, moist, painful, 2 areas of blisters, open measuring 3 x 2 cm 6x6 cm.</p> <p>Review of a Wound Management note for R1, Most Recent Documentation dated 4/17/25 at 11:15 AM, revealed, the wound was identified on 3/25/25 at 5:00 PM and measured 3.6 cm x 6.1 cm.</p> <p>Review of R1's altered skin integrity care plan dated 3/13/25 revealed, resident acquired altered skin integrity to right inner thigh-hot liquid spill. Approaches included 4/16/25 Resident, Family educated on risk benefit of regulated temperature to hot liquids & foods. Temps do not exceed 120 degrees.</p> <p>Review of the facility Hot Liquid ACTION PLAN/PNC (past noncompliance) date 3/26/25 revealed, Concern leading to AP (action plan) development. Facility identified that hot liquids are not monitored for temperature prior to leaving the dietary department. Facility identified that the dietary and nursing staff were not using the care plan and the care guides to identify interventions that were in place for residents who are at risk of injury from hot liquids. Facility actions resulted in resident having burns from a coffee spill. Standard of Practice included: Hot Liquids are not to be served at a temperature greater than 135 degrees F (Fahrenheit), unless care plan has specific identified alternatives. Dining room service with be supervised. Resident having meals in rooms will be monitored. Resident at high risk will require 1 to 1 supervision.</p> <p>The facility policy review revealed a water temperature burn guide that indicated at 3rd Degree burn can occur in 1 second with a temperature of 155 degrees, 2 seconds at 148 degrees, 5 seconds at 140 degrees, 15 seconds at 133 degrees, 1 minute at 127 degrees, 3 minutes at 124 degrees and 5 minutes at 120 degrees.</p> <p>During an interview with Dietary Aide (DA) J on 4/15/25 at 3:58 PM, J was not aware of any details of a resident having a coffee burn. J said the dietary manager was currently on vacation. J was aware of recent education and said she does not allow coffee out on the counter to be served until it is below 150 degrees. Thermometers were available for staff to get temperature readings prior to serving residents coffee. J said she does not serve the coffee and was not aware of the temperature requirements for the residents. One cup of coffee was poured, and temperature was 136.3 degrees. (See policy Temperature was to be below 135 degrees).</p> <p>CNA I was interviewed on 4/16/25 at 8:25 AM. CNA I was aware R1 had sustained a burn last month when he spilled hot coffee on himself. CNA I said the facility had lowered the serving temperature of the coffee to 140 degrees or less. She said R1 could have coffee in a regular cup with a lid in the dining room at 140 degrees or less. CNA I said R1 can have coffee in his room but was not sure at what temperature and did not mention the need to supervise him in either location.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON) on 4/16/25 at 10:37 AM, the DON did not have any incident or accident report for R1's thigh burn that occurred on 3/25/25. The DON said she started on 4/7/25 and became aware of the burn and stated on education and a plan of correction. She located kitchen logs that indicated the coffee temperature that day was around 170 degrees. The new policy allows the serving temperature of coffee to be 135 degrees. She said R1 was provided a special cup for his coffee with a lid that is more difficult to remove. She said all residents were evaluated and care plans were up to date. The DON said R1 was not his own responsible party, and they had not met with his responsible party to ensure they agreed to coffee at 135 degrees. The DON had a chart that indicated that a 3rd degree burn could occur in less than 15 seconds with a hot liquid at 133 degrees. Concern was raised that even with supervision how could the facility ensure staff could respond in under 15 seconds. The DON was also informed that interviews and observations did not confirm staff were serving at the proper temperature or were aware of special equipment for R1. The surveyor reviewed R1's admission hot liquid assessment with the DON and expressed concern as the boxes marked did not match progress notes or observations for items like vision, dementia and cognitive impairment. The DON was not able to indicate any instructions or rational for the discrepancy in the items marked.</p> <p>On 4/16/25 at 12:00 PM the kitchen brought a cart down the hall to serve meals to residents in their room. Staff ensured that coffee provided to resident in their room was under 120 degrees.</p> <p>During an observation on 4/16/25 at 12:10 PM, R4 was served lunch in her room with the DON present. R4 complained that the coffee was not hot enough. The DON said she would evaluate her for hot liquids with the use of a special cup to prevent spilling. (R4 had not been evaluated for hot liquids prior as indicated by DON).</p> <p>During a telephone interview with the Nursing Home Administrator (NHA) on 4/16/25 at 10:03 AM, the NHA confirmed that he was aware R1 had sustained a burn when he spilled coffee on himself on 3/25/25. The NHA said he was not aware of the extent of injury at the time. When he returned from his vacation, he was aware of the severity of burn, and he did not report it to the State Agency or start a plan of correction.</p>		