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	01/07/2026

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

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(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 - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP) and failed to store linens in a manner that would prevent the spread of infection, resulting in the potential for increased risk of respiratory infection among all residents in the facility and resulting in the increased risk of adverse outcomes for residents.Water:On 01/06/2026 at 11:12AM, observed in kitchen, two water lines coming out of floor under a stainless-steel counter. One of the lines did not provide water to any equipment and was capped at the end, this line was over 12 inches long from the point it comes out of the floor. The other line branched off into two different areas, one of those lines that branched off was also capped off over 6 inches from the point it branched off, the other branched off and fed the coffee maker. In an interview on 01/06/2026 at 2:40PM, Maintenance Supervisor (MS) J disclosed he was unaware of these lines and has not been flushing them. In an observation on 01/06/2026 at 2:50PM, in the [NAME] Hallway B bathing room, two capped water lines coming out of the wall. Interview with MS J disclosed the removal of the tub was within the past year, currently the lines are not being flushed as there is no easy access to flush them. Review of the Water Pathogen Risk Reduction policy; states 5. Routine reassessment annually and when there are changes that could impact risk. Linen:In an observation on 01/06/2026 at 3:20 PM, in [NAME] Hallway A bathing room, there was a linen cart with clean linens stored on it, the covering used for the cart was a blue mesh that would allow for infiltration from airborne droplets from toilet being flushed, handwashing or possible bodily fluids. The linen cart was stored partially in front of the toilet, allowing access to the toilet and the handsink across the wall from the linen cart. In an interview on 01/06/2026 at 3:20PM, Maintenance Supervisor (MS) J stated the cart is stored in bathing room when the shower or toilet are not in use.

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to consistently conduct and document care conferences for 1 resident (R8) of 2 residents reviewed for care conferences. Findings include: Review of a resident Face Sheet revealed R8 admitted to the facility on [DATE] with pertinent diagnoses which included cardiomegaly, major depressive disorder, restless legs syndrome, lymphedema, and morbid obesity. Review of R8's electronic medical record on 01/06/2026 at 3:01 PM showed no evidence that required quarterly care conferences were held in 2025 for R8 until August 19, 2025. In an interview and record review on 1/6/2026 at 3:27 PM the Social Worker (SW) G revealed that care conferences are scheduled quarterly (occurring every three months). SW G could not locate any care conferences for R8 prior to August 19, 2025. SW G confirmed the facility has met with R8, but SW G was terrible with documentation. Review of facility policy/procedure Resident's Rights to Participate in Planning Care, updated 5/30/18, revealed .The Resident, resident representative and/or family members as requested by the resident will be invited to attend all care conferences and review and request revisions to the care plan, which will be conducted.following the completion of an OBRA (Omnibus Budget Reconciliation Act) assessment (defined as a schedule of assessments that will be performed for a nursing facility resident on admission, quarterly, and annually) , OR as requested by the resident or resident representative.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to address grievances for 1 resident (R30) out of 12 of residents reviewed.Findings included: Based on observation, interview and record review the facility failed to address grievances for 1 resident (R30) out of 12 of residents reviewed.Findings included:Review of R30's face sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included acute and chronic respiratory failure, pneumonia, chronic obstructive pulmonary disease, and sleep apnea. R30 was her own responsible party.R30 was observed in bed on 1/5/26 at 11:44 AM. R30 was using oxygen at 4 liters via an oxygen concentrator (machine). The oxygen concentrator and a breathing machine were at the end of R30's bed out of her eyesight and reach. R30 complained of staff taking off her breathing machine when she was not fully awake and not putting her nasal canula in place for her oxygen. R30 said this was a daily problem. R30 reported that new staff do not know how to provide care for her and the other day one of the nurses refused to hold her urinal for her. R30 said she does not currently have a back brace that fits right, and she keeps asking when she is going to get a brace as she cannot tolerate being out of bed long due to back pain. R30 was very upset and said she gets very worked up because no one listens to her.Review of R30's BEHAVIOR NOTE: dated 1/2/26 at 9:03 AM revealed, (R30's name) is with call light on. Agency CENA (Certified Nurse Assistant) in to answer call light. R30 tells CENA I need my pee cup. Per report from day shift CENA, R30 needs assist with applying urinal but can hold it (per agency CENA). Agency CENA assisted with placement and told R30 she would be back in a few minutes to empty it. R30 begins screaming at the CENA and throws the urinal at the CENA. R30 tells nurse that she can not use pee cup with out staff assistance. R30 says she would prefer to just pee in a diaper. R30 is swearing and screaming at nurse, pointing her finger in nurses face during this conversation.During an interview with Certified Nurse Aide (CNA) N on 1/6/26 at 8:32 AM, CNA N was asked about R30. CNA N said R30 can not hold her urinal and is frequently upset when new staff do not provide the care she needs. CNA N was aware of the incident when the Agency CNA did not hold the urinal. CNA N said the licensed nurses are aware of the concerns.During an interview with the Director of Nursing (DON) on 1/6/26 at 8:53 AM the DON was asked if she was aware of R30's concerns about staff not holding R30's urinal and reporting she can do it herself. The DON denied knowledge of R30 being upset with care and staff not holding her urinal during care. The DON reviewed R30's progress note dated 1/2/26 at 9:03 AM which revealed R30 was having behaviors and the agency nurse did not hold R30's urinal during care. The DON confirmed R30 cannot hold her own urinal and the staff involved need to be educated. The DON did not know anything about R30's back braces.During an interview with R30 on 1/6/26 at 9:13 AM, R30 said sometime this morning she woke up and her breathing machine was off, and she was not on oxygen. R30 said staff did not respond to her call light so she called the facility and told them if someone did not get in there immediately to put her oxygen on, she was going to call 911. Review of R30's cell phone outgoing phone log revealed that she had called the facility at 5:13 AM on 1/6/26. R30 was in bed at this time with her oxygen at 4 liters.During an interview with the Nursing Home Administrator (NHA) on 1/6/26 at 9:15 AM the NHA confirmed that R30 had made the same allegation to him about being left this morning without oxygen and he was in the process of investigating this and reporting it to the State.During an interview with the Director of Nursing (DON) on 1/6/26 at 9:36 AM the DON confirmed that she was just told about R30's allegation of being left with her breathing machine off and no oxygen earlier this morning. All documentation related to R30's respiratory assessment, treatments and breathing equipment was requested at this time.During an interview with the DON on 1/7/26 at 7:52 AM the DON said she was looking into the oxygen concern from 1/6/26 and did not have any information on R30's back braces other than the one she was admitted with. DON could not locate any (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information on the other braces R30 had received since admission.During an interview with the Nursing Home Administrator (NHA) on 1/7/26 at 8:03 AM the NHA said she was still investigating R30 allegation related to not having her oxygen in place on 1/6/26 and he said he did not have any concern forms from R30. He confirmed staff had not made him aware of R30 concern about staff refusing to hold her urinal during care or any other care concerns. He was aware R30 had several back braces since admission but was not aware she still did not have a back brace that met her needs.Review of R30's care plan dated 4/25/25 revealed, R30 requires use of BIPAP R/T (related to) 4/26/17 diagnosis of obstructive sleep apnea. The goal revealed, R30 use of BIPAP machine will assist her to breathe more easily and promote rest/sleep and prevent further rehospitalization d/t (due to) acute respiratory failure with hypoxia and hypercapnia (excessive carbon dioxide in bloodstream). Interventions included: BiPap machine setting will be preset by company supplier. There was no indication of when the BiPap was to be used or how much assistance R30 required with set up and use.Review of R30's ADL (activities of daily living) care plan dated 4/7/25 revealed she required assistance of 2 people and a mechanical lift for transfers. There was no indication how much assistance she needed to use her breathing machine. There was no indication she used a urinal.Review of R30 care plan dated 4/2/25 revealed, (R30's name) has potential for/actual pain related to lumbar compression fracture of L4, effect of chronic heart failure, adverse effects of DM (diabetes mellitus) and cardiac events. There was no indication a back brace was ever issued or used.Review of the facility Grievances/Concerns policy dated 1/2023 revealed, Purpose: To support each resident's right to voice grievances and ensure that a policy is in place to process grievance. Providing prompt actions to resolve grievances/concerns and to keep the resident appraised of progress toward resolution. Procedure: 4. Upon receipt of a grievance, an immediate action will be implemented to prevent further potential violation of any resident right while the alleged violation is being investigated. 5. If an alleged violation involving neglect, abuse, including injuries of unknown source, and or misappropriation of resident property is reported the facility will reference and follow Abuse & Neglect Procedures, Standards of Care Volume. A Grievance/Complaint Form was attached to the policy. Upon exit the facility did not provide any Grievance/Complaint Forms for R30.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medications at discharge or attempt to assist with a safe discharge plan for 1 resident (R45) of 1 resident reviewed for discharge planning. Findings include:Review of an admission Record revealed R45 admitted to the facility on [DATE] with pertinent diagnoses which included chronic respiratory failure and repeated falls. Review of R45's Discharge Against Medical Advice document dated 10/12/2025 at 11:34 AM revealed he was discharged from the facility the morning of 10/12/2025 against medical advice (AMA) by Registered Nurse (RN) B. Review of R45's Progress Note dated 10/12/2025 written by RN B revealed R45 demanded to be discharged that morning so that he could take his medications the way he would like. RN B instructed R45 if he left AMA he would be discharged without medications, equipment, oxygen, home health services, or therapy. R45 left the facility with friends at 11:50 AM without medications or services. In a telephone interview on 1/7/2026 at 9:28 AM, RN B stated when residents leave AMA, We try to educate them to stay as much as possible, but sometimes they decide to go AMA, and we can't change their mind. We have been trained that when they go AMA, they go without anything. RN B confirmed R45 left the facility AMA the morning of 10/12/2025 without attempting to meet any of R45's discharge needs. RN B reported R45 had medication at the facility, but he was not given these medications upon his AMA discharge. In an interview on 1/7/2026 at 9:58 AM with the Director of Nursing (DON) and Regional Nurse A, the DON confirmed facility staff had been trained not to attempt to provide medication or services to residents when they discharge AMA. Regional Nurse A reported she would like to see an attempt to provide as much support and services as possible in AMA discharge situations.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide 1 Resident (R50) and his representative with a written and completed baseline care plan within 48 hours of admission of 4 residents reviewed for care plans.Findings included:Review of R50's face sheet, no date, revealed he was a [AGE] year-old male admitted to the facility on [DATE] he had diagnoses that included: Sepsis, opioid use, spinal stenosis, heart failure and glaucoma. He was his own responsible party and had an emergency contact.During an interview with R50 on 1/5/26 at 10:36 AM, R50 expressed concerns about his care and discharge plans. R50 said he had not received a care plan since administration.During an interview with Social Worker (SW) G on 1/6/26 at 11:39 AM, SW G was informed R50 had care and discharge concerns. SW G was asked about the baseline care plan, and she said nursing provided the baseline care plan. SW G reported they try to do a care conference within 72 hours but because of the holiday they did not get to do a care conference until 1/5/26. SW G said they do not provide a written care plan at the care conference.Review of R50's baseline care plan dated 12/29/25 revealed the Director of Nursing (DON) completed the baseline care plan, resident discharge goals, home, resident goals on admission for NF (nursing facility) stay, Rehab Services, Therapy Orders was blank, PT (physical therapy) was blank, OT (Occupational Therapy) was blank, ST (Speech Therapy) was blank, he was at risk of infection, Skilled resident utilizing their Medicare Benefit, and Medication, Matrix (electronic medical record system used by the facility).During an interview with the Director of Nursing (DON) on 1/7/26 at 11:00 AM, the DON reviewed R50's baseline care plan for R50 and confirmed she completed it. The care plan did not list R50's medications, it did not give the frequency of any therapy visits, there was no indication of nursing assistance being provided or assistance required for care and it did not give any indication R50's advocate was contacted or provided a copy of the care plan. There was no indication that R50 was provided with a written copy of his baseline care plan. The DON was asked if R50's advocate was contacted and she said no. The DON was asked if she provided R50 and his advocate a copy of his baseline care plan and she said, no.Review of the facility Baseline care plan policy, no date revealed, Intent: To ensure each resident receives necessary care and services upon admission. Completion and implementation of the baseline care plan within 48 hours of the resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety and safeguard against adverse events that are most likely to occur right after admission; and to ensure the resident and representative, if applicable, are informed of the initial plan for delivery of care and services by receiving a written summary of the of the baseline care plan.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to develop and implement a comprehensive respiratory care plan for 1 resident (R30) out of 1 resident reviewed for respiratory care.Findings included:Review of R30's face sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included acute and chronic respiratory failure, pneumonia, chronic obstructive pulmonary disease, and sleep apnea. R30 was her own responsible party.R30 was observed in bed on 1/5/26 at 11:44 AM. R30 was using oxygen at 4 liters via an oxygen concentrator (machine). The oxygen concentrator and breathing machine were at the end of R30's bed out of her eyesight and reach. R30 complained of staff taking off her breathing machine when she was not fully awake and not putting her nasal canula in place for her oxygen. R30 said this was a daily problem.During an interview with R30 on 1/6/26 at 9:13 AM, R30 said sometime this morning she woke up and her breathing machine was off, and she was not on oxygen. R30 said staff did not respond to her call light so she called the facility and told them if someone did not get in there immediately to put her oxygen on, she was going to call 911. Review of R30's cell phone outgoing phone log revealed that she had called the facility at 5:13 am on 1/6/26. R30 was in bed at this time with her oxygen at 4 liters.During an interview with the Nursing Home Administrator (NHA) on 1/6/26 at 9:15 AM, the NHA confirmed that R30 had made the same allegation to him about being left this morning without oxygen and he was in the process of investigating this and reporting it to the State.During an interview with the Director of Nursing (DON) on 1/6/26 at 9:36 AM, the DON confirmed that she was just told about R30's allegation of being left with her breathing machine off and no oxygen earlier this morning. All documentation related to R30's respiratory assessment, treatments and breathing equipment was requested.During an interview with the DON on 1/7/26 at 7:52 AM, the DON reviewed R30's Electronic Medical Record (EMR) and could not find any respiratory assessments documentation or R30 being followed by a pulmonologist. The DON could not determine when R30's breathing machine had last been assessed or what breathing machine was currently in use. The DON said the equipment company providing the breathing machine was contacted and has provided them with a report on R30's equipment currently in use. The DON was able to get hospital records (not the facility records) and could see R30 was evaluated when she was in the hospital in September 2025 and specific settings for R30's AVAP machine (Average Volume Assured Pressure) were recommended. The DON had no way to confirm R30 had the breathing machine recommended by the hospital or if the machine was at the settings recommended.Review of R30's Physician progress note dated 10/19/25 at 8:38 AM revealed, admission visits for exacerbation of acute on chronic hypercapnic hypoxic respiratory failure. 3. Chronic hypoxic hypercapnic respiratory failure requires BiPAP (Bilevel Positive Airway Pressure) pursuant to further diagnosis of obesity hypoventilation syndrome. No BiPap settings were documented. There was no indication of a change in equipment or setting changes as indicated when the DON reviewed R30's hospital notes from September 2026. (DON interview indicated R30 should have been on an AVAP machine, not a BiPAP machine).Review of R30's care plan dated 4/25/25 revealed, R30 requires use of BIPAP R/T (related to) 4/26/17 diagnosis of obstructive sleep apnea. The goal revealed, (R30) use of BIPAP machine will assist her to breathe more easily and promote rest/sleep and prevent further rehospitalization d/t (due to) acute respiratory failure with hypoxia and hypercapnia (excessive carbon dioxide in bloodstream). Interventions included: BiPap machine setting will be preset by company supplier. There was no indication of when the BiPap was to be used or how much assistance R30 required with set up and use. There was no indication of any ongoing respiratory assessments or monitoring of the BiPap machine functions/setting. There was no indication how they were to monitor the machine was in use when the resident was sleeping or how they would monitor or be alerted if it came off during (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sleep.Review of R30's ADL (activities of daily living) care plan dated 4/7/25 revealed she required assistance of 2 people and a mechanical lift for transfers. There was no indication how much assistance she needed to use her breathing machine.Review of R30's medical equipment report dated 10/1/25 to 1/6/26 (provided to the facility on 1/7/26) revealed R30 had a Resumed AirView machine with settings at Mode iVAPS, Target Alveolar Ventilation 4.6 L/min, EPAP 10 cmH2O, Min PS 16 cm H2O, Mas PS 20 cmH20, Target Patient Rate 14 bpm. (This machine did not have a care plan).During an interview with the DON on 1/7/26 at 11:15 am, the DON said R30 did not currently have the machine that was recommended by the hospital in September 2025. The equipment company supplying the machine has a Respiratory Therapists and they reviewed R30's equipment function report on 1/6/26. They reported that R30's breathing report showed improvement, and they would be out today to assess R30 and make equipment recommendations to R30's physician and set up a program for monitoring safety/use, ongoing assessment and respiratory care for R30. All hospital respiratory records and facility respiratory records were requested for a second time. Upon exit no hospital records for R30 were provided. No pulmonary physician notes were provided. No ongoing respiratory assessments were provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide showers as ordered for 1 resident (R50) out of 12 residents reviewed for care.Findings included:Review of R50's face sheet, no date, revealed he was an [AGE] year-old male admitted to the facility on [DATE] he had diagnoses that included: Sepsis, opioid use, spinal stenosis, heart failure and glaucoma. He was his own responsible party.R50 was observed in his room in a recliner on 1/5/26 at 10:36 AM. R50 had general care concerns and reported he had not had a shower since admission on [DATE] and when he requested one this morning, he was told his shower days are Wednesday and Saturday.During an interview with Certified Nurse Aide (CNA) N on 1/5/26 at 10:45 AM, CNA N confirmed that R50 had inquired about his shower this morning and she told him his shower days were Wednesday and Saturday. The Surveyor asked if she knew why R50 had not received a shower since admission and CNA N said she had no idea, but she would look into it and make sure he got a shower today.During an interview with the Director of Nursing (DON) on 1/6/26 at 11:49 AM, the DON reviewed R50's medical record to see if she could determine if R50 had a shower since admission. The DON could not locate any documentation indicating he had been offered a shower since admission. The DON said showers are assigned by room and R50 should have been offered showers on Wednesday and Saturday during the day shift. On admission the nurse is to create and order for this. The DON discovered the order was not entered correctly and proceeded to correct the order. The DON was aware R50 did receive a shower on 1/5/26 after the Surveyor inquired about R50's lack of showers. Upon exit no documentation was provided that showers were attempted during the first week of admission.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess, monitor and effectively treat the respiratory condition of 1 resident (R30) of 1 resident reviewed for respiratory care.Findings include:Review of R30's face sheet revealed she was a [AGE] year-old female admitted to the facility on [DATE] and had diagnoses that included acute and chronic respiratory failure, pneumonia, chronic obstructive pulmonary disease, and sleep apnea. R30 was her own responsible party.R30 was observed in bed on 1/5/26 at 11:44 AM. R30 was using oxygen at 4 liters via an oxygen concentrator (machine). The oxygen concentrator and breathing machine were at the end of R30's bed out of her eyesight and reach. R30 complained of staff taking off her breathing machine when she was not fully awake and not putting her nasal canula in place for her oxygen. R30 said this was a daily problem.During an interview with R30 on 1/6/26 at 9:13 AM, R30 said sometime this morning she woke up and her breathing machine was off, and she was not on oxygen. R30 said staff did not respond to her call light so she called the facility and told them if someone did not get in there immediately to put her oxygen on, she was going to call 911. Review of R30's cell phone outgoing phone log revealed that she had called the facility at 5:13 am on 1/6/26. R30 was in bed at this time with her oxygen at 4 liters.During an interview with the Nursing Home Administrator (NHA) on 1/6/26 at 9:15 AM, the NHA confirmed that R30 had made the same allegation to him about being left this morning without oxygen and he was in the process of investigating this and reporting it to the State.During an interview with the Director of Nursing (DON) on 1/6/26 at 9:36 AM, the DON confirmed that she was just told about R30's allegation of being left with her breathing machine off and no oxygen earlier this morning. All documentation related to R30's respiratory assessment, treatments and breathing equipment was requested.During an interview with the DON on 1/7/26 at 7:52 AM, the DON said all the night shift staff had not been interviewed yet to determine what happened with R30 at 5:13 AM when she allegedly was left without oxygen. The DON reviewed R30's Electronic Medical Record (EMR) and could not find any respiratory assessments documentation or R30 being followed by a pulmonologist. The DON could not determine when R30's breathing machine had last been assessed or what breathing machine was currently in use. The DON said the equipment company providing the breathing machine was contacted and has provided them with a report on R30's equipment use. The DON was able to get into hospital records (not the facility records) and could see R30 was evaluated when she was in the hospital in September 2025 and specific settings for R30's AVAP machine (Average Volume Assured Pressure) were recommended. The DON had no way to confirm R30 had the breathing machine recommended by the hospital or if the machine was at the settings recommended.Review of R30's progress note dated 1/6/26 at 1:39 PM revealed, Recorded as late entry on 1/7/26 at 7:25 AM, Follow up with (R30's name) following the situation this morning. She reports that she called the facility two times. (R30's name) showed me what time she called. I saw the last time she called was at 5:13 am. She stated that she is calming down after being worked up this morning. She said she needs them to make sure she is awake and she puts on her O2 in the morning, she woke up with her CPAP in her hand, then proceeded to punch her hand to show me where it was. She was feeling anxious this morning when she felt like she needed air. Review of R30's Physician progress note dated 10/19/25 at 8:38 AM revealed, admission visits for exacerbation of acute on chronic hypercapnic hypoxic respiratory failure. 3. Chronic hypoxic hypercapnic respiratory failure requires BiPAP (Bilevel Positive Airway Pressure) pursuant to further diagnosis of obesity hypoventilation syndrome. No BiPap settings were documented. There was no indication of a change in equipment or setting changes as indicated when the DON reviewed R30's hospital notes from September 2026. (DON interview indicated R30 should have been on an AVAP machine, not a BiPAP machine).Review of R30's care plan dated 4/25/25 revealed, R30 requires use of BIPAP R/T (related to) 4/26-17 diagnosis of obstructive sleep apnea). Goal revealed, R30 use of BIPAP machine (continued on next page)

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	01/07/2026

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will assist her to breathe more easily and promote rest/sleep and prevent further rehospitalization d/t (due to) acute respiratory failure with hypoxia and hypercapnia (excessive carbon dioxide in bloodstream). Interventions included: BiPap machine setting will be preset by company supplier. There was no indication of when the BiPap was to be used or how much assistance R30 required with set up and use.Review of R30's ADL (activities of daily living) care plan dated 4/7/25 revealed she required assistance of 2 people and a mechanical lift for transfers. There was no indication how much assistance she needed to use her breathing machine.Review of R30's progress note dated 1/7/26 at 4:49 AM revealed, Resident asked RN (registered nurse) to remove CPAP (Continuous Positive Airway Pressure and administer the O2, it was completed and spo2 98% CPAP cleaned and stored. (physician note referred to BiPap, hospital records referred to AVAP, and this nurse indicated the machine was CPAP).Review of R30's medical equipment report dated 10/1/25 to 1/6/26 (provided to the facility on 1/7/26) revealed R30 had a Resumed AirView machine with settings at Mode iVAPS, Target Alveolar Ventilation 4.6 L/min, EPAP 10 cmH2O, Min PS 16 cm H2O, Mas PS 20 cmH20, Target Patient Rate 14 bpm.During an interview with the DON on 1/7/26 at 11:15 am, the DON said R30 did not currently have the machine that was recommended by the hospital in September 2025. The equipment company supplying the machine has Respiratory Therapists and they reviewed R30 equipment function report on 1/6/26. They reported that R30's breathing report showed improvement, and they would be out today to assess R30 and make equipment recommendations to R30's physician and set up a program for monitoring safety/use, ongoing assessment and respiratory care for R30. All hospital respiratory records and facility respiratory records were requested for a second time. Upon exit no hospital records for R30 were provided. No pulmonary physician notes were provided. No ongoing respiratory assessments were provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the monthly drug regimen review recommendations for 1 resident (R40) of 5 residents reviewed were accurately addressed. Findings include: Review of a resident Face Sheet revealed R40 admitted to the facility on [DATE] with pertinent diagnoses which included chronic systolic (congestive) heart failure, cardiomyopathy, major depressive disorder, type 2 diabetes mellitus with diabetic polyneuropathy, and seasonal allergic rhinitis. Review of R40's Consultation Report recommendation dated 10/22/2025 revealed Please discontinue Loratadine. Review of the Physician's Response revealed a line through I accept the recommendation above, please implement as written. The Physician signature on the report was dated 10/28/25. Review of R40's Progress Notes dated 10/28/2025 revealed Pharmacy recommendation to stop Loratadine to avoid adverse reactions attributed to daily long-term use. Doctor gave okay to discontinue medication. Resident aware. Review of R40's Physician's Orders on 1/7/2026 at 10:33 AM revealed an active order for Loratadine tablet 10 mg once a day PRN (as needed) started 10/28/25. Further review of the electronic Medication Administration Record revealed Loratadine tablet 10 mg had been administered on 11/1/25, 11/2/25, 11/29/25, and 12/27/25. In an interview and record review on 01/07/2026 at 10:27 AM, the Director of Nursing (DON) reported R40's Consultation Report review recommendation dated 10/22/2025 had not been accurately addressed by the facility. The DON was unable to produce documentation that Loratadine should have been continued. Review of facility policy/procedure Medication Regimen Review, reviewed 06/01/24, revealed .facility should independently review each resident's medication regimen directly from the resident's medical record and with interdisciplinary care team members.to rule out any medication dispensing or administration errors .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation and interview, the facility failed to provide adequate access to the call light system, increasing the risk of possible adverse outcomes for residents who use the [NAME] Hallway A bathing room. Findings include: During an observation on 01/06/2026 at 3:45 PM, there was not a pull cord for the call light in the shower of the [NAME] Hallway A bathing room, not allowing accessibility for residents who may have fallen or could not reach the call light on the shower wall. In an interview on 1/6/26 at 3:45 PM, Maintenance Supervisor (MS) J indicated he was not aware the pull cord was missing, at that time he validated the call light was functional. MS J said the [NAME] Hallway A bathing room is generally used by residents in the Main hallway and [NAME] Hallway A.