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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/17/2025
NAME OF PROVIDER OR SUPPLIER: Gladwin Pines Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 449 Quarter Street 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 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** 45410 This citation pertains to intake #MI00147001. Based on interview and record review, the facility failed to document resident concerns according to facility policy for 2 residents (Resident #102 and #103), of 4 residents reviewed for grievance resolution. Findings include: R102 Review of an Admission Record revealed Resident #102 (R102) admitted to the facility on [DATE] with pertinent diagnoses which included cerebral infarction (stroke), weakness, and hypertension. In an interview on 1/16/2025 at 2:40 PM, R102 reported ongoing issues with the facility regarding optometry care, receipt of mail, voting privileges, receipt of requested documents, and access to medical providers of her choice. R102 reported she had discussed these unresolved concerns many times with staff, including the Director of Nursing (DON), and had never received any written or formal response to her ongoing complaints. Review of R102's Progress Notes revealed a note written by the DON on 11/5/2023 at 10:34 AM at which time R102 was described as becoming angry after discussing her optometry complaints and told the DON that she would call the state and file a complaint. Per email correspondence from the Nursing Home Administrator (NHA) received on 1/16/2025 at 9:23 AM, the facility did not have any grievance/concern forms for R102 in the previous 3 months. In an interview on 1/16/2025 at 12:30 PM, the DON reported she had discussed some of R102's ongoing complaints with her, including her ongoing optometry complaint described in the Progress Note on 11/5/2024. The DON reported that she had not assisted R102 to fill out a formal grievance. The DON acknowledged she should have initiated the formal grievance process which includes a written response to the resident. R103 (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Admission Record revealed Resident #103 (R103) admitted to the facility on [DATE] with pertinent diagnoses which included dementia, Parkinson's disease, and need for assistance with personal care. In a telephone interview on 1/15/2025 at 9:47 AM, Family Member (FM) of R103 J reported ongoing complaints regarding the care of R103 including being left wet, not being repositioned, inconsistent shaving, and care of R103's nails. In a telephone interview on 1/17/2025 at 10:17 AM, FM J reported she had frequent conversations with staff, including the DON and NHA, regarding her ongoing and unresolved complaints about the care of R103. FM J reported she had not received any written response from the facility regarding her concerns. In an interview on 1/17/2025 at 11:40 AM, the NHA reported the facility had not filled out any grievance forms regarding the concerns of Family Member of R103 J and had not provided a written response to the concerns. The NHA stated the facility needed to do better regarding concern documentation and follow up. Review of facility policy/procedure Complaint, Reviewed June 2010, revealed .Purpose . To ensure that complaints are investigated and the results of the investigation are reported back to the complainant within a reasonable time period . Any resident, guardian of a resident, authorized representative, or any interested party . may file a formal complaint related to: The care and service a resident is or is not receiving . Any violation of the resident's rights . Complaints made to the facility may be oral or in writing . If an oral complaint is not resolved to the satisfaction of the complainant, the individual receiving the complaint will assist in reducing an oral complaint to writing . Within 30 days, a written report of the investigation or a written report indicating when the report may be expected shall be delivered to the complainant .

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 This citation pertains to intake #MI00149026. Based on interview and record review, the facility failed to prevent significant medication errors for 1 resident (Resident #101) of 4 residents reviewed for medication administration, resulting in Resident #101 (R101) becoming bradycardic (low heart rate) and requiring to be transferred to a local hospital for treatment. Findings include: Review of an Admission Record revealed Resident #101 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and congestive heart failure. Review of R101's Medication Discrepancy report, dated 12/13/2024 at 7:40 AM, revealed R101 received the wrong resident's medications the morning of 12/13/2024. Further review revealed the facility Medical Doctor (MD) K was contacted by Registered Nurse (RN) A. Facility MD K gave orders for nursing staff to monitor R101's vital signs and hold his morning medications. Review of R101's Provider Progress Notes, dated 12/13/2024 at 11:07 AM, revealed MD K documented R101 received the wrong patient's medications including 1) Colace 100mg (a stool softener laxative), 2) Aspirin 81mg (a nonsteroidal anti-inflammatory used to reduce pain, fever, and inflammation), 3) metoprolol 25mg (a beta-blocker used to treat high blood pressure that can cause bradycardia), 4) Renflexis 75mg (used to treat arthritis), 5) atorvastatin 20mg (used to treat hyperlipidemia), 6) sotalol 80mg (a beta-blocker used to treat arrhythmias that can cause bradycardia), 7) leflunomide 20mg (used to treat arthritis), 8) pantoprazole 40mg (used to treat gastroesophageal reflux disease, 9) gabapentin 100mg (used to treat nerve pain), 10) MiraLAX 17g (a laxative used to treat constipation), 11) bupropion 75mg (used to treat depression), 12) ibuprofen 400mg (a nonsteroidal anti-inflammatory used to reduce pain, fever, and inflammation), and 13) metformin 850mg (used to treat diabetes). Further review revealed R101's morning medications were held on 12/13/2024. R101's vital signs were monitored, and he developed bradycardia with his pulse confirmed by MD K to be in the high 40's (normal pulse range is between 60-100 beats per minute). Further review revealed .Given that low heart rate and that he got patient's wrong medications including metoprolol and sotalol will have ER (emergency room) evaluate . Review of R101's Emergency Department Provider Notes, dated 12/13/2024 at 4:45 PM, revealed R101 was evaluated and monitored at the local Emergency Department for 8 hours following the ingestion of the wrong medications per recommendations from Poison Control. In a telephone interview on 1/16/2025 at 9:10 AM, RN A reported that she set up R101's medications the morning of 12/13/2024 and another resident's medications with the same first name. RN A reported it was busy, and she asked RN E to give R101 the medications that she had prepared. RN A stated, We shouldn't do that, reporting nurses are expected to administer medications that they prepare. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	In at telephone interview on 1/17/2024 at 9:00 AM, RN E reported RN A handed medication to her the morning of 12/13/2024 and asked her to administer them to R101. RN E reported she administered the medications that RN A had prepared to R101, and then RN A realized that the medications were given to the wrong resident. RN E reported nurses should not give medications that were prepared by another nurse under normal circumstances. In an interview on 1/16/2025 at 9:50 AM, the Director of Nursing (DON) reported nursing staff should not administer medication that another nurse prepared. Review of facility policy/procedure Medication Administration by the Various Routes, reviewed December 2024, revealed .Only authorized personnel who prepare the medication may administer it . Medications supplied for one resident are not administered to another resident .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410 Based on interview and record review, the facility failed to maintain an accurate Electronic Health Record (EHR) for two residents (Resident #101 and #102), of 5 residents reviewed for accuracy of medical records. Findings include: R101 Review of an Admission Record revealed Resident #101 (R101) admitted to the facility on [DATE] with pertinent diagnoses which included dementia and congestive heart failure (CHF). Review of R101's Medication Discrepancy report, dated 12/13/2024 at 7:40 AM, revealed R101 received the wrong resident's medications the morning of 12/13/2024. Further review revealed Facility Medical Doctor (MD) K was contacted by Registered Nurse (RN) A. Facility MD K gave the order for nursing staff to monitor R101's vital signs and hold his morning medications. Review of Resident #101's December 2024 Medication Administration Record (MAR) revealed 3 medications were documented as being given to R101 the morning of 12/13/2024 by Registered Nurse (RN) A, including 1) Claritin 10mg (used to treat allergic rhinitis), 2) Donepezil 10mg (used to treat dementia), and 3) furosemide 20mg (a diuretic used to treat CHF). In a telephone interview on 1/16/2025 at 9:10 AM, RN A reported she did not give any of R101's scheduled medications the morning of 12/13/2024 based on orders received from the medical provider. RN A stated, I thought I unchecked these. In an interview on 1/16/2025 at 9:50 AM, the Director of Nursing (DON) reviewed R101's December 2024 MAR and confirmed that Claritin, Donepezil, and furosemide were documented as being given by RN A the morning of 12/13/2025. R102 Review of an Admission Record revealed Resident #102 (R102) admitted to the facility on [DATE] with pertinent diagnoses which included cerebral infarction (stroke), weakness, and hypertension. Further review revealed Family Member (FM) of R102 I to be R102's active Durable Power of Attorney (DPOA) as of 1/16/2025. Review of R102's Progress Notes revealed a note documented by Social Services Director (SSD) H on 10/22/2024 at 4:20 PM indicating R102 revoked FM I as her DPOA on that date. In an interview on 1/16/2025 at 11:20 AM, SSD H reported R102 revoked FM I from being her DPOA on 10/22/2024 and the EHR was incorrect and needed to be updated. SSD H reported FM I should be listed as a responsible party and not as the DPOA. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy/procedure Interdisciplinary Documentation and Admission Assessments, revised January 2017, revealed .Purpose: To communicate about the care provided, promote good interdisciplinary care and provide support to meet professional and legal standards. To enhance the continuity of care and decrease duplication of data collection and ensure that all those involved in resident care have access to reliable, pertinent, and up-to-date resident information upon which to plan and evaluate interventions .