STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235485	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gladwin Pines Nursing and Rehabilitation Center	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 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** This citation refers to MI00152903. Based on interview and record review, the facility failed to conduct a thorough investigation for 1 of 3 residents (R2) reviewed for abuse/neglect. Findings include: A review of R2's admission Record, dated 7/8/25, revealed they were an [AGE] year-old resident that was admitted to the facility on [DATE]. In addition, R2's admission Record revealed multiple diagnoses that included late onset Alzheimer's Disease, anxiety, and generalized muscle weakness. A review of R2's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 5/20/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 1 which revealed R2 was severely cognitively impaired. A review of the facility's 5-Day Investigation, dated 5/7/25, revealed on 5/1/25 at 2:40 PM the social worker (Social Services Director (SSD) D) was assessing R2's psychosocial status when R2 indicated the night aide pushed her against the wall. R2 stated she reported this to someone from activities. R2's roommate, who was alert and oriented, stated she was awake all night and she did not hear anything. A skin assessment was completed, and no signs of redness or bruising were noted. In addition, the facility's 5-Day Investigation revealed R2 had documented bowel movements and care on 4/30/25 at 9:21 PM (afternoon shift) and 5/1/25 at 12:30 AM (night shift). A further review of the facility's 5-Day Investigation revealed the facility interviewed R2, Certified Nursing Assistant (CNA) A (the alleged perpetrator), CNA B (CNA A's hall partner from 2:30 PM to 10:30 PM), and Activity Aide (AA) C (who R2 named). However, the facility's 5-Day Investigation failed to reveal that CNA F (CNA A's hall partner from 10:00 PM to 6:30 AM), SSD D (whom R2 reported the allegation to), and/or Licensed Practical Nurse (LPN) G (who was R2's assigned nurse from 6:00 PM to 6:30 AM) provided written statements and/or were interviewed. During an interview on 7/9/25 at 8:40 AM, SSD D stated she did not document a statement or progress note in R2's medical record. She stated she probably gave a written note to the Nursing Home Administrator (NHA) about her interview with R2 when she reported the allegation to her but could not recall if she did. (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/9/25 at 10:15 AM, the NHA stated she did not interview any staff members that worked from 10:00 PM to 6:00 AM the night of the alleged incident. She stated she realized that the alleged incident occurred at 12:30 AM, but she only interviewed CNA 's that worked with CNA A from 6:00 PM to 10:30 PM. The NHA confirmed that she also did not interview LPN G who worked from 6:00 PM to 6:30 AM the night of the alleged incident. The NHA also verbalized since she did not interview any staff members (besides CNA A) who worked from 10:30 PM to 6:30 AM (4/30/25 to 5/1/25), she does not know for sure what may/may not have happened when CNA A provided incontinence care to R2 on 5/1/25 at 12:30 PM. The NHA further stated CNA A would have provided incontinence care to R2 alone unless R2's care plan indicated two people were required. A review of R2's Altered Functional Mobility and ADL's (Activities of Daily Living) care plan, revised on 10/17/24, revealed R2 was a two-person assist for elimination (e.g., using the toilet and incontinence care). Therefore, CNA F should have been interviewed to determine if they assisted CNA A with incontinence care on 5/1/25 at 12:30 AM and what, if anything, they witnessed. A review of the State Operations Manual (SOM), revised 4/25/25, revealed, The facility must take the following actions in response to an alleged violation of abuse, neglect, exploitation or mistreatment: Thoroughly investigate the alleged violation . For all alleged violations of abuse, neglect, exploitation, misappropriation of resident property, exploitation, and mistreatment, including injuries of unknown source . the facility must thoroughly collect evidence to allow the Administrator to determine what actions are necessary (if any) for the protection of residents. Depending upon the type of allegation received, it is expected that the investigation would include, but is not limited to . Conducting interviews with, as appropriate, the alleged victim and representative, alleged perpetrator, witnesses . A review of the facility's Abuse/Suspected Abuse Investigation & Reporting Policy and Procedure, revised February 2023, revealed the facility's investigation may consist of an interview with the person(s) reporting the incident, interviews with any witnesses, and an interview with staff members having contact with the resident during the period/shift of the alleged incident. However, the facility's policy is not entirely consistent with the SOM as the facility's policy implies that interviews with the person(s) reporting the incident, witnesses, and staff members having contact with the resident during the period/shift of the alleged incident may be optional and the SOM indicates that interviews of witnesses (e.g., staff having contact with the resident during the period/shift of the alleged incident and the person(s) reporting the incident) are expected, as appropriate.

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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** This citation refers to MI00152903. Based on interview and record review, the facility failed to maintain a complete and accurate medical record for 1 of 3 residents (R2) reviewed. Findings include: Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice . Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines . It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care . High quality documentation, however, is a necessary and integral aspect of the work of registered nurses in all roles and settings . Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care . Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org, retrieved on 7/10/25). A review of R2's admission Record, dated 7/8/25, revealed they were an [AGE] year-old resident that was admitted to the facility on [DATE]. In addition, R2's admission Record revealed multiple diagnoses that included late onset Alzheimer's Disease, anxiety, and generalized muscle weakness. A review of R2's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 5/20/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 1 which revealed R2 was severely cognitively impaired. A review of the facility's 5-Day Investigation, dated 5/7/25, revealed on 5/1/25 at 2:40 PM the social worker (Social Services Director (SSD) D) was assessing R2's psychosocial status when R2 indicated the night aide pushed her against the wall. R2 stated she reported this to someone from activities. R2's roommate, who was alert and oriented, stated she was awake all night and she did not hear anything. A skin assessment was completed, and no signs of redness or bruising were noted. In addition, the facility's 5-Day Investigation revealed the Nursing Home Administrator (NHA) and Director of Nursing (DON) were notified on 5/1/25 at 2:20 PM, the local authorities (law enforcement) was notified on 5/1/25 at 3:55 PM, the health care provider (HCP) was notified on 5/1/25 at 4:10 PM, and R2's guardian was notified on 5/1/25 at 4:10 PM. A review of R2's progress notes, dated 4/23/25 to 7/8/25, revealed the following: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Interdisciplinary Documentation, dated 5/9/25, revealed, SSD talked with [name of R2]. [Name of R2] said she was tired but doing ok. [Name of R2] was at activities enjoying reading and music. [Name of R2] was enjoying everyone's company. There were no signs of distress at all. However, the note did not indicate the reason for SSD's discussion with R2 (e.g., routine assessment/evaluation, follow-up for an incident, impromptu visit). - No note mentioning R2 reporting an incident to SSD D on, or around, 5/1/25. A review of R2's Skin Assessment, dated 5/1/25, failed to reveal any skin abnormalities, except for R2's heels were slightly red and mushy. However, it did not reveal why the skin assessment was performed (e.g., post-incident, routine). A further review of R2's complete electronic medical record (EMR), dated 4/23/25 to 7/8/25, failed to reveal any mention that R2 had alleged that a staff member had pushed her against the wall. In addition, R2's EMR failed to reveal that the NHA and DON, R2's guardian, the HCP, and/or the local authorities were notified of any alleged incident with R2. During an interview on 7/9/25 at 8:40 AM, SSD D stated when a resident makes an accusation, she will document it in a progress note. She stated she would also document if she notified anyone. SSD D reviewed R2's medical record and stated she did not see where she wrote a note. She stated she probably gave a written note to the NHA when she reported the incident to her. SSD D also stated that she reviewed her follow-up note on 5/9/25 and stated the note was not very clear on why she was interviewing R2 (e.g., follow-up to an incident, routine assessment, routine conversation about care and how the resident is doing). She stated she usually documents the reason why she talks to a resident in the progress note along with their response. During an interview on 7/9/25 at 9:00 AM, Registered Nurse (RN) E stated when a resident falls or has an incident with another resident or staff member, she would report it to the DON. She stated she would also document the incident in a progress note and who she called. RN E stated she would always document that she called someone for anything related to a resident. During an interview on 7/9/25 at 11:30 AM, the NHA stated SSD D should have written a progress note when R2 reported to her that staff had pushed her against the wall. She also stated that staff should have documented when they notified her, the DON, R2's guardian, the HCP, and local authorities (law enforcement) in a progress note.