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	09/11/2025

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents received timely and accurate assessments and monitoring for changes in condition for five of eight residents (Resident #77, Resident #45, Resident #51, Resident #7, and Resident #46) reviewed for quality of care. Findings: Resident #77 (R77) Review of an admission Record revealed R77 was an [AGE] year-old-male, originally admitted to the facility on [DATE] following a 15-day hospital stay, with pertinent diagnoses of a urinary tract infection (UTI), a stage 4 pressure ulcer of the sacrum, congestive heart failure, diabetes mellitus, low blood pressure, and retention of urine. R77 was admitted to the facility as a full code and was able to answer questions. Review of an Inpatient Discharge Summary for R77 dated 07-24-25 at 10:58 AM reflected the following information regarding R77's hospital stay and discharge orders: (a) on 07-14-25, R77 had a surgical excision and debridement of a stage 4 sacral wound, and a wound vacuum (negative pressure wound therapy) was placed, (b) continue wound vac (vacuum) at discharge, and (c) Outpatient Wound Treatment Clinic will need referral placed. An additional hospital consultation note indicated that a diverting colostomy was not advised by the surgeon at that time because the wound vac dressing fit well and provided a tight barrier against stool leaking into the sacral wound. Review of a Medical Equipment Work Order for R77 revealed an order, placed by facility staff and delivered to the facility on [DATE], for a wound vac kit. During an interview on 09-10-25 at 2:10 PM, Medical Records Coordinator (MRC) Q stated that the wound vac was delivered to the facility on [DATE] but staff had not signed for it, and MRC Q did not know where the wound vac was placed after it arrived at the facility. Review of a Skin Assessment for R77, completed by nursing on 07-26-25, reflected no wound measurements nor mention of the ordered and delivered wound vac. Review of a nursing Progress Note for R77, dated 07-27-25, revealed a moderate amount of drainage was noted in the sacral wound. Review of a nursing Progress Note for R77, dated 07-28-25, revealed no documentation regarding the condition of the stage 4 sacral wound. Review of a nursing Progress Note for R77, dated 07-29-25, revealed a large amount of drainage was noted in the sacral wound. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a nursing Progress Note for R77, dated 07-30-25, revealed a moderate to large amount of drainage and a faint odor were detected in the sacral wound. Review of an Electronic Treatment Administration Record (Etar) for R77, dated 07-31-25, revealed an order for Negative Pressure Wound Therapy (NPWT) to sacrum. Set vacuum at 125 mmHg (millimeters of mercury). Set to continuous. Inspect settings and visualize dressing is intact every shift. Change every 3 days starting 07-31-25 (seven days after the wound vac equipment had been delivered to the facility). Review of the corresponding Wound Measurement assessment, also completed 07-31-25 for R77, revealed the wound measured 8 cm (centimeters) long x 7.8 cm wide x 2 cm deep that included undermining from 7 o'clock to 12 o'clock that measured approximately 2 cm. Additional documentation on the 07-31-25 Wound Measurement assessment included questions/answers regarding additional descriptives of the sacral wound and the current condition of other skin areas, as well as a narrative written by the nurse regarding assessment notes and review of treatment effectiveness. Review of a nursing Progress Note for R77, dated 08-01-25, revealed no documentation that the dressing for the wound vac was sealed and functioning properly. Review of a nursing Progress Note for R77, dated 08-02-25, revealed no documentation that the dressing for the wound vac was sealed and functioning properly. Review of a nursing Progress Note for R77, dated 08-03-25, revealed no documentation about the change to the wound vac and the condition of the wound including the size, color, amount of drainage, if an odor was detected, or if the dressing for the wound vac was sealed and functioning properly when the dressing change was completed. Review of the next Wound Measurement assessment for R77, completed on 08-05-25, revealed the exact same measurements as those obtained on 07-31-25, the exact same answers to the questions regarding additional descriptives of the sacral wound as those documented on 07-31-25, and the exact same narrative written by nursing regarding assessment notes and review of treatment effectiveness. Review of a nursing Progress Note for R77, dated 08-05-25, revealed no documentation about the change to the wound vac and the condition of the wound including the size, color, amount of drainage, if an odor was detected, or that the dressing for the wound vac was sealed and functioning properly when the dressing change was completed. Additional review of the Etar for R77, dated July 2025, revealed an order for daily weight upon admission for three days. A weight was obtained on 07-25-25 but not on 07-26-25 and 07-27-25. Review of nursing progress notes for 07-26-25 and 07-27-25 revealed no documentation that explained why the last two daily weights were not obtained. Review of the Emar's (Electronic Medication Administration Record) and Etar's for R77 dated July 2025 and August 2025, revealed an order for staff to monitor and record urine output twice daily when emptying the foley (catheter in the bladder to evacuate urine) drainage bag. No documentation for urine output was found for 07-26-25 in the morning, 07-27-25 in the morning, 07-30-25 in the morning, 08-05-25 in the morning, 08-09-25 both in the morning and in the evening, and 08-10-25 in the evening. Review of the Inpatient Discharge Summary for R77 revealed an order to continue Midodrine 5mg (milligrams) twice daily. Midodrine was used to treat hypotension (low blood pressure) and was prescribed with parameters. The hospital administered the medication and used a blood pressure of (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	90/50 or lower for the parameter. The facility administered Midodrine to R77 without the use of any parameters starting the evening of 07-28-25 until the evening of 08-10-25. (24 doses) Review of an interdisciplinary progress note for an Admission-5 day MDS (minimum data set) review for R77, with the interview documented as completed on 07-28-25, revealed the following: (R77) is here to continue with skilled therapy to regain his strength and endurance so he can return home and (R77) is usually understood and usually understands others verbally. Review of a physician order for R77, dated 07-31-25, revealed an order for a U/A with C&S (urine analysis with a culture and sensitivity) due to a change in R77's mentation (cognitive status). Review of the U/A with C&S for R77, resulted on 08-03-25, revealed R77 had a UTI caused by the bacteria Escherichia Coli (E.Coli) and further noted the phenotypic resistance profile of this isolate is suggestive of an ESBL-producing Enterobacterale. During an interview on 09-11-25 at 10:40 AM, Infection Control Preventionist (ICP) E reported that he had not notified the physician about the results of the U/A and C&S for R77 that were completed on 08-03-25. ICP E stated that R77 was already taking an antibiotic for the UTI identified in the hospital. When ICP E was asked if the antibiotic that R77 was currently prescribed (Linezolid) was resistant or susceptible (effective or not) against E.Coli, ICP E reported not knowing. When ICP E was asked if he notified anyone of the U/A and C&S results for R77, ICP E stated no. Review of a facility prescriber Progress Note dated 08/05/25 reflected no documentation that indicated the nurse-practioner (NP) was made aware of the results of the U/A and C&S for R77 that had been resulted on 08-03-25. Further review of R77's electronic health record (EHR) revealed no documentation that any facility prescriber was made aware of U/A results from 08-03-25 prior to the resident's passing on 08-12-25. Resident #45 (R45) Review of an admission Record revealed R45 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: acute on chronic congestive heart failure (CHF). Review of R45’s “Heart Failure Clinic” consultation report dated 1/10/25 revealed, “…weigh yourself every morning; if you notice a weight gain of > 2 lbs in one day or > 5 lbs in one week, call our office…” Review of R45’s “Order Summary” dated 7/9/24 revealed, “Order Summary: Daily Weights for CHF.” Review of R45’s “Weight Summary” revealed her weights were not obtained on the following days: 7/3/25, 7/5/25, 7/7/25, 7/11/25-7/13/25, 7/16/25, 7/18/25, 7/20/25, 7/21/25, 7/26/25, 7/27/25, or 7/31/25. Confirming the order to notify the provider with a 2 lb weight increase in 1 day could not be completed due to insufficient monitoring. *7/9/25 a weight of 244 lbs, 7/10/25 a weight of 245.3 lbs, (no weights 7/11/25-7/13/25), 7/14/25 a weight of 249.5 lbs, 7/15/25 a weight of 249.6, and no weight obtained 7/16/25. Indicating R45 had a 5.6 lb weight gain in 1 week. There was no documentation that the provider was notified of the weight gain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	*7/24/25 a weight of 238.2 lbs and 7/25/25 a weight of 242.2 lbs. Indicating R45 had a 4 lb weight gain in 1 day. There was no documentation that the provider was notified of the weight gain. Review of R45’s July “Treatment Administration Record” revealed: The weight obtained on 7/2/25 (240 lbs) was documented for the 7/3/25 weight assessment. The weight obtained on 7/4/25 (240.3 lbs) was documented for the 7/5/25 weight assessment. The weight obtained on 7/6/25 (240 lbs) was documented for the 7/7/25 weight assessment. The weight obtained on 7/15/25 (249.6 lbs) was documented for the 7/18/25 and 7/19/25 weight assessments. The weight obtained on 7/30/25 (242.4 lbs) was documented for the 7/31/25 weight assessment. Review of R45’s “Weight Summary” revealed her weights were not obtained on the following days: 8/1/25, 8/9/25, 8/12/25, 8/14/25-8/17/25, or 8/22/25. Review of R45’s August “Treatment Administration Record” revealed: The weight obtained on 8/11/25 (243.3 lbs) was documented for the 8/12/25 weight assessment. The weight obtained on 8/13/25 (243.5 lbs) was documented for the 8/14/25 and 8/17/25 weight assessments. Review of R45’s “Weight Summary” revealed her weights were not obtained on the following days: 9/3/25, 9/4/25, 9/5/25, or 9/6/25. Review of R45’s September “Treatment Administration Record” revealed: The weight obtained on 9/2/25 (243. lbs) was documented for the 9/3/25 weight assessment. Review of R45’s “Electronic Health Record” revealed no documentation for the rationale for not obtaining R45’s weights as ordered. Resident #51 (R51) Review of an admission Record revealed R51 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: systolic and diastolic congestive heart failure. Review of R51’s “Order Summary” dated 2/17/25 revealed, Weight M-W-F (Monday, Wednesday, and Friday). If weight increases by more than 2-3 lbs (pounds) on consecutive measurements or more than 5 lbs. in a week, let provider know in the morning for Fluid overload/CHF (Congestive Heart Failure).” Review of R51’s “Weight Summary” revealed that on 5/6/2025 R51’s weight was 177.8 pounds and on 5/9/2025 R51’s weight was 184.0 pounds (6.2-pound weight gain). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R51’s “Weight Summary” revealed her weight was not obtained on 8/1/25, 8/18/25, or 8/25/25. Review of R51’s “Weight Summary” revealed R51’s weight was obtained on 6/30/25 (180.4 lbs) and was not obtained again until 7/7/25. Review of R51’s July “Treatment Administration Record” revealed that the weight obtained on 6/30/25 was documented for the 7/2/25 and 7/4/25 weight assessment. Review of R51’s “Weight Summary” revealed R51’s weight was obtained on 8/6/25 (180.9 lbs) and was not obtained again until 8/11/25. Review of R51’s August “Treatment Administration Record” revealed that the weight obtained on 8/6/25 was documented for the 8/8/25weight assessment. Review of R51’s “Electronic Health Record” revealed no documentation for the rationale for not obtaining R51’s weight on 8/1/25, 8/18/25, or 8/25/25 or documentation that the provider was notified of the 6.2-pound weight gain. A request for documentation that the provider was notified of the 6.2-pound weight gain was requested via email on 09/11/2025 at 10:59 AM. No supporting documentation was received prior to survey exit. Resident #7 (R7) Review of an admission Record revealed R7 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: chronic atrial fibrillation (abnormal beating of the heart). Review of R7’s “Order Summary” dated 7/3/25 revealed, “daily weight one time a day for chf.” Review of R7’s “Weight Summary” revealed no weights were obtained on 7/11/25, 7/12/25, 7/14/25, 7/19/25/25, or 7/20/25. Review of R7’s July “Treatment Administration Record” revealed: The weight obtained on 7/13/25 (100.8 lbs) was documented for the 7/14/25 weight assessment. The weight obtained on 7/18/25 (99.6 lbs) was documented for the 7/19/25 weight assessment. Review of R7’s “Weight Summary” revealed no weights were obtained on 8/2/25, 8/8/25, 8/16/25-8/18/25, 8/22/25, 8/25/25, or 8/31/25 Review of R7’s August “Treatment Administration Record” revealed: The weight obtained on 8/1/25 (100.6 lbs) was documented for the 8/2/25 weight assessment. The weight obtained on 8/7/25 (101.9 lbs) was documented for the 8/2/25 weight assessment. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The weight obtained on 8/15/25 (103 lbs) was documented for the 8/17/25 weight assessment. The weight obtained on 8/21/25 (103.2 lbs) was documented for the 8/22/25 weight assessment. The weight obtained on 8/24/25 (104.6 lbs) was documented for the 8/25/25 weight assessment. The weight obtained on 8/30/25 (105.6 lbs) was documented for the 8/31/25 weight assessment. Review of R7’s “Electronic Health Record” revealed no documentation for the rationale for not obtaining R7’s weights. Resident #46 (R46) Review of an admission Record revealed R46 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: heart failure. Review of R46’s “Order Summary” dated 9/3/24 revealed, “Weigh M-W-F - If weight increase by more than 2-3 lbs. on consecutive measurements or more than 5 lbs. in a week, let provider know for chf.” Review of R46’s “Weight Summary” and “Medication Administration Record” revealed her weight was not obtained on 7/2/25, 7/9/25, 8/25/25 or 8/27/25. Review of R46’s “Electronic Health Record revealed no documentation for not obtaining R46’s weights. During an interview via email on 09/11/2025 at 4:23 PM, Regional Nurse Consultant (RNC) “A” confirmed the above residents had missing daily weights and confirmed licensed nurses were utilizing the previous weights in the “Treatment Administration Record” documentation. RNC “A” reported the licensed nurses would receive education regarding the assessment and documentation of daily weights. The facility did not have a policy for congestive heart failure. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Daily weights are an important indicator of fluid status. Each kilogram (2.2 lb) of weight gained or lost overnight is equal to 1 L of fluid retained or lost…Weigh patients with heart failure daily…” [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 1059). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, A weight gain of 0.9 to 1.4 kg (2–3 lb) in 1 day indicates fluid-retention problems… daily weight is measured at the same time of day and on the same scale (Ball et al., 2019). This allows an objective comparison of subsequent weights. Accuracy of weight measurement is important because health care providers base medical and nursing decisions (e.g., drug dosage, medications) on changes…” [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 558). Elsevier Health Sciences. Kindle Edition.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility policy for pressure injury/wound management and ensure treatments were ordered and completed, for 3 of 17 residents (Resident #15, #7, and #5), reviewed for the treatment and prevention of pressure injuries.Findings:Resident #15 (R15) Review of an admission Record revealed R15 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pressure ulcer of the sacral region with osteomyelitis (infection in the bone.) Review of R15’s “Order Summary” dated 7/27/25 revealed an active order (as of 9/11/25) for “Dakins (full strength) External Solution 0.5 % (Sodium Hypochlorite) Apply to Coccyx Wound topically every shift for Wound cleansing.” Review of R15’s wound clinic “Physician Orders Details” dated 8/1/25 revealed, “…The periwound skin appearance exhibited: Maceration, Rubor…Wound Treatment-Wound #2 Coccyx Cleanser: Dakins Solution 0.5 % 3 X Per Day…Use FULL STRENGTH DAKIN’S SOLUTION to rinse wound then use to apply wet-to-dry dressing Peri-Wound Care: Clotrimazole and Betamethasone 3 X Per Day… Peri-Wound Care: Coloplast CitricAid Clear AF Antifungal 3 X Per Day…every 2 hours and as needed after incontinence episodes Secondary Dressing: Woven Gauze Sponge…3 X Per Day… Secondary Dressing: Tegaderm Film 4x4…3 X Per Day…use to secure dressing, sealed down on three sides, open at the top…” The top of the document was time stamped 08/01/2025 at 4:44 PM with the wound clinics name indicating a fax to the facility was successful/received. The document did not include a fax cover page (page 1) but pages 2-5 were present. Per the State Operations Manual, “Macerated skin has a white appearance and a very soft, sometimes “soggy” texture. The persistent exposure of perineal skin to urine and/or feces can irritate the epidermis and can cause severe dermatitis, skin erosion and/or ulcerations.” Review of R15's Wound Measurement dated 8/1/25 revealed her wound measured 4.1cm length x 1.4cm width x 1.5cm depth. The periwound skin assessment indicated “intact-unbroken skin. Maceration was not documented. Chronic sacral wound, managed by wound care clinic. The wound vac was discontinued by the wound clinic. New orders for cleansing with Dakin's solution 0.5% and wet to dry with Dakin's solution. Cleaning is provided day shift and day shift as well as PRN after bowel movements due to the location of the wound. Her stool tends to go up towards the wound when she has a bowel movement. Wound Clinic requests for resident to reposition every two hours and in a chair for only up to 1 hour maximum. Complicating factors include continued pressure on wound, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	uncleanly practices, lack of proteins and pt's (patients) dementia, incontinence, educated both pt and spouse about importance of offloading to treat this wound . The facility referenced a diagnosis of dementia indicating R15 would require reminders for offloading/repositioning. The interventions to reposition every two hours and for the resident to be up in a chair for only 1 hour maximum were not implemented on R15’s care plan. Review of R15's Wound Measurement dated 8/7/25 revealed her wound measured 4.0cm length x 1.4cm width x 1.4cm depth. The periwound skin assessment indicated “intact-unbroken skin. Maceration was not documented. Chronic sacral wound, managed by wound care clinic. Orders for cleansing with Dakin's solution 0.5% and wet to dry with Dakin's solution. Cleaning is provided day shift and day shift (sic-presumed night shift) as well as PRN (as needed) after bowel movements due to the location of the wound .Wound Clinic requests for resident to reposition every two hours and in a chair for only up to 1 hour maximum. Complicating factors include continued pressure on wound, uncleanly practices, lack of proteins and pt's (patients) dementia, incontinence, educated both pt and spouse about importance of offloading to treat this wound . The interventions to reposition every two hours and for the resident to be up in a chair for only 1 hour maximum were not implemented on R15’s care plan. Review of R15’s “Order Summary” dated 8/7/25 revealed, “Wound (Coccyx): 1. Use full strength Dakin's solution to rinse wound. 2. Use Dakin's to apply wet-to-dry dressing. 3. Secondary dressing: Woven Gauze Sponge. 4: Secure with Tegaderm Film 4x4, sealed down on three sides, leave open at the top. Peri-Wound (Coccyx): Apply Clotrimazole and Betamethasone to the peri-wound with dressing changes. three times a day for Wound Care.” Indicating the treatment change wasn’t implemented for 6 days following the order change at the wound clinic. Additionally, Coloplast CitricAid was not initiated as directed by the wound clinic. Review of R15’s wound clinic “Physician Orders Details” dated 8/15/25 revealed, “…Her wound is still being contaminated with her loose stool and it had to be extensively cleansed of stool contamination today and the debrided… the peri-wound skin appearance exhibited: Rash, Maceration, Rubor…” Additional treatments to initiate with the previous order included: “Impressions/Recommendations: Peri-Wound Care: Duoderm 3x Per Day…apply around wound as a donut Peri-Wound Care: Stoma paste 3 x Per Day…” Review of R15’s wound clinic “Consultation Report” (completed at the time of the wound clinic appointment) dated 8/15/25 revealed, “…Pt (patient) to be checked + (and) changed Q1 hr (every hour), while awake. Q2 (every 2 hours) during sleep. Peri wound- -ostomy paste-duoderm to periwound -Dakins W – D (wet to dry) to wound bed -Top Layer Tegaderm (change) BID +PRN (twice a day and as needed) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Cheeks & between legs -Acetic acid wash -ATF & Lotrisone (antifungal cream)…” The fax cover indicated the fax was successful/received on 8/15/25. Review of R15's Wound Measurement dated 8/15/25 revealed her wound measured 2.7cm length x 1.9cm width x 1.5cm depth. The periwound skin assessment indicated “intact-unbroken skin. Maceration was not documented. Chronic sacral wound, managed by wound care clinic. Orders for cleansing with Dakin's solution 0.5% and wet to dry with Dakin's solution. Cleaning is provided day shift and day shift as well as PRN after bowel movements due to the location of the wound Wound Clinic requests for resident to reposition every two hours and in a chair for only up to 1 hour maximum. Complicating factors include continued pressure on wound, uncleanly practices, lack of proteins and pt's dementia, incontinence, educated both pt and spouse about importance of offloading to treat this wound. Wound clinic notes that stool continues to contaminate the wound The facility confirmed the wound clinic notes were reviewed, however, R15's treatment order was not changed in the TAR at that time. Additionally, the wound note indicated the dressing change was being completed twice a day and not three times as directed by the wound clinic. The interventions to reposition every two hours and for the resident to be up in a chair for only 1 hour maximum were not implemented on R15’s care plan. Review of R15's Wound Measurement dated 8/19/25 revealed her wound measured 2.7cm length x 1.9cm width x 1.5cm depth. The periwound skin assessment indicated “intact-unbroken skin. Maceration was not documented. Chronic sacral wound, managed by wound care clinic. Orders for cleansing with Dakin's solution 0.5% and wet to dry with Dakin's solution. Cleaning is provided day shift and day shift as well as PRN after bowel movements .Wound was cleaned as instructed by orders. No measurement changes since the wound clinic visit on Friday .She was given education on calling to be changed as soon as she realizes she has had an incontinence episode to help reduce the amount of feces that gets into the dressing and wound . The note indicated wound care completed as instructed by orders however R15's treatment changes from 8/15/25 continued to go unchanged. The interventions to reposition every two hours and for the resident to be up in a chair for only 1 hour maximum were not implemented on R15’s care plan. The wound was not assessed again until 8/29/25 (10 days). Review of R15's Wound Measurement dated 8/29/25 revealed her wound measured 2.6cm length x 1.9cm width x 1.5cm depth. The periwound skin assessment indicated “intact-unbroken skin. Maceration was not documented. Chronic sacral wound, managed by wound care clinic. Orders for cleansing with Dakin's solution 0.5% and wet to dry with Dakin's solution. Cleaning is provided day shift and day shift as well as PRN after bowel movements due to the location of the wound .Education provided about offloading, protein intake, hygiene, and letting staff at SNF (skilled nursing facility) know when she is incontinent. She states understanding, but has dementia . Confirming the facility was aware that R15 required reminders to offload pressure and frequent check and changes. R15's treatment changes from 8/15/25 continued to go unchanged. The interventions to reposition every two hours and for the resident to be up in a chair for only 1 hour maximum were not implemented on R15’s care plan. Review of R15's Wound Measurement dated 9/5/25 revealed her wound measured 2.5cm length x (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1.5cm width x 1.5cm depth. The periwound skin assessment indicated “intact-unbroken skin. Maceration was not documented. Chronic sacral wound, managed by wound care clinic. Orders for cleansing with Dakin's solution 0.5% and wet to dry with Dakin's solution. Cleaning is provided day shift and day shift as well as PRN after bowel movements. Wound Clinic requests for resident to reposition every two hours and in a chair for only up to 1 hour maximum. Complicating factors include continued pressure on wound, uncleanly practices, lack of proteins and pt's dementia, incontinence, educated both pt and spouse about importance of offloading to treat this wound . The interventions to reposition every two hours and for the resident to be up in a chair for only 1 hour maximum were not implemented on R15’s care plan. Review of R15’s “Order Summary” dated 9/9/25 revealed, “Gently cleanse buttocks, groin and peri area and pat dry. Apply Bag Balm ointment to macerated areas. every shift for Skin protectant on macerated skin.” Bag Balm was ordered prior to the implementation of the wound clinic treatments for the periwound. The wound clinics treatment orders continued to go unordered (25 days). Review of R15’s “Interdisciplinary Documentation” dated 9/9/2025 revealed, “Wound: dressing to coccyx completed, large amount of wetness noted. wound bed is moist and pink, surrounding tissue red as well as buttocks and groin hot red, no odor. Bag balm being applied. (R15) is sleeping on a pressure reduction mattress. She does fairly well with bed mobility herself…” Indicating the resident required assistance with bed mobility and offloading pressure. Review of R15’s “Interdisciplinary Documentation” dated 9/10/2025 revealed, “(R15) dressing to her coccyx done large amount of drainage she has a red excoriated rash to her groin, peri area, between her legs and buttocks. She seems to have a constant stream of urine making it a wet environment. Bag balm being applied as ordered…” Indicating the worsening of R15’s skin breakdown. Review of R15’s “Order Summary” revealed no order for ostomy paste and Duoderm to periwound or for acetic acid wash and ATF & Lotrisone for “cheeks & between legs” as of 9/11/25 (27 days). Review of R15’s “Electronic Health Record” revealed no documentation/rationale for the lack of implementation of the wound clinics treatment orders. Review of R15’s “Interdisciplinary Documentation” dated 9/10/2025 revealed, “Resident experiencing frequent episodes of urinary incontinence. Spoke to resident about placing a foley catheter to help with moisture control in order to heal her macerated skin and coccyx wound. Resident voiced understanding and agreed with placement of indwelling foley cath…” Indicating R15’s wound did not show improvement and continued to present with maceration. The facility placed a foley catheter to prevent ongoing breakdown prior to implementing the wound clinics treatment for her periwound. Review of R15’s “Order Summary” dated 9/10/25 revealed, “Place foley catheter for skin integrity one time only for wound healing.” Review of R15’s August “Treatment Administration Record (TAR)” revealed multiple missed treatments for the coccyx treatment ordered on 8/7/25. Missed treatments as (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	follows: 8/8/25 9:00 AM and 2:00 PM treatments, 8/9/25 10:00 PM treatment, 8/13/25 10:00 PM treatment, 8/16/25 10:00 PM treatment, 8/22/25 10:00 PM treatment, 8/25/25 9:00 AM, 2:00 PM, and 10:00 PM treatments, 8/31/25 2:00 PM treatment. Review of R15’s “Order Summary” and July, August, and September “Treatment Administration Record (TAR)” revealed: *An order for Dakins (full strength) External Solution 0.5 % (Sodium Hypochlorite) Apply to Coccyx Wound topically every shift (day shift and night shift)…” Began on 7/27/25 and was ongoing as of 9/10/25. The facility nurses continued to document on the TAR that the treatment was completed. *An order for Betamethasone Dipropionate External Cream 0.05 % (Betamethasone Dipropionate (Topical)) Apply to peri-wound (coccyx) topically every shift…” Began on 7/27/25 and continued until it was put on hold on 9/7/25. The facility nurses continued to document on the TAR that the treatment was completed. Review of R15's wound clinic “Physician Orders Details” intervention recommendations from 8/1/25, 8/15/25, and 8/29/25 revealed, .Off-Loading .Turn and reposition every 2 hours-limit time in wheelchair to 1 hour with each meal and then return to bed .Bathing/Shower/Hygiene .may shower, rewash wound after showering . Additionally, the wound “Consultation Report” dated 8/15/25 recommended R15 to be checked and changed every hour, while awake and every 2 hours during sleep. Review of R15’s “Care Plan” with revisions revealed none of the wound clinic’s intervention recommendations were transcribed or implemented. During an interview on 09/11/2025 at 9:57 AM, Regional Nurse Consultant (RNC) “A” was notified of concerns pertaining to R15’s treatment orders not initiated promptly or at all, her care plan not updated with wound clinic recommendations, treatments not completed, and previous treatments not discontinued. Resident #7 (R7) Review of an admission Record revealed R7 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pressure ulcer of buttock. Review of R7’s “Order Summary” dated 7/17/25 revealed an active order (as of 9/11/25) for “Left Ischium: cleanse with acetic acid, apply Collagen prism to wound bed, Apply Mepilex border dressing 4x4. Every day shift for wound care.” Review of R7’s wound clinic “Physician Orders Details” dated 8/20/25 revealed, “Wound #3 (left ischium) is healed today…” Review of R7’s “Wound Measurement” report dated 8/21/25 revealed, “…The right Ischial wound has been noted as healed by the wound clinic. We will continue to monitor for changes but will heal the wound for weekly assessments. Wound care notes 8/20/25 Left ischium healed…” Confirming the facility reviewed the wound clinic “Physician Orders Details.” (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R7’s wound clinic “Physician Orders Details” dated 8/27/25 revealed no documentation/assessments or any new treatments for R7’s Left Ischial wound. Confirming the wound had healed. Review of R7’s “Skin Assessment” dated 8/27/25 revealed, “…Left ischium wound is healing with continued treatment order…” Indicating an inaccurate assessment of R7’s skin. Review of R7’s “Wound Measurement” report dated 8/28/25 revealed, “…The right Ischial wound has been noted as healed by the wound clinic. Discontinue wound treatment .” Review of R7’s wound clinic “Physician Orders Details” dated 9/3/25 revealed no documentation/assessments or any new treatments for R7’s Left Ischial wound. Confirming the wound had healed. Review of R7’s “Skin Assessment” dated 9/3/25 revealed, “…Left ischium wound is healing with continued treatment order…” Indicating an inaccurate assessment of R7’s skin. Review of R7’s “Wound Measurement” report dated 9/3/25 revealed, “…The right Ischial wound has been noted as healed by the wound clinic. We will continue to monitor for changes but will heal the wound for weekly assessments after 2 weeks have passed and it remains healed. Wound clinic notes…” Review of R7's wound clinic “Physician Orders Details” dated 8/20/25, 8/27/25, and 9/3/25 revealed, “Wound Treatment…Wound #2-Sacrum-Cleanser: Acetic Acid Irrigation…with each dressing change do a 5 minute wound soak with acetic acid… Wound #3 (Left Ischium) Secondary Dressing: Mepilex Border Dressing, 4x4 every other day.” Review of R7’s “Order Summary” revealed no order for the Mepilex Border Dressing for the left ischium or for the acetic acid wound soak for the sacrum as ordered by the wound clinic. Review of R7’s August and September “Treatment Administration Record” revealed the treatment for “Left Ischium: cleanse with acetic acid, apply Collagen prism to wound bed, Apply Mepilex border dressing 4x4 every day shift for wound care” continued to be completed through 9/11/25. Review of R7's wound clinic “Physician Orders Details” intervention recommendations from 8/20/25, 8/27/25, and 9/3/25 revealed, .Off-Loading .Turn and reposition every 2 hours *Other: - Time in chair must be limited to 30 minutes to 1 hour MAX at a time (at mealtimes 3 times per day). Pressure on buttocks MUST be limited . Bathing/Shower/Hygiene *May shower with protection but do not get wound dressing(s) wet. Protect dressing(s) with water repellant cover (for example, large plastic bag) and may then take shower . Review of R7’s “Care Plan” with revisions revealed none of the wound (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	clinic’s intervention recommendations were transcribed or implemented. During an interview via email on 09/11/2025 4:23 PM, RNC “A” stated, “treatment for (R7) should have been discontinued when noted (the left ischial wound) healed and was not.” During an interview on 09/11/2025 at 9:57 AM, RNC “A” and the Director of Nursing (DON) were notified of treatment order discrepancies and wound clinic care planned interventions not implemented for R15 and R7. RNC “A” and DON reported additional and/or supporting documentation would be provided if found. RNC “A” reported that they had identified that there was a delay in the wound clinic providing their progress notes/consultation reports which resulted in treatment order changes not being implemented promptly. On 09/11/2025 at 1:26 PM a request for any additional supporting documentation regarding R15 and R7’s pressure injuries was requested to be submitted by 5:30 PM. No additional documentation was received. R5 Review of an “admission Record” revealed R5 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and complete paraplegia (loss of motor and sensory function). Review of a current end of life Care Plan intervention for R5, initiated revised 2/24/2025, revealed “…Hospice has been elected and the facility & hospice will coordinate care & services…” Review of activities of daily living “Care Plan” intervention for R5, initiated 9/6/2024, revealed R5 was using an Alternating Pressure Air Mattress (APM). (APM mattresses use a pump to inflate and deflate cells or channels within the mattress in a cyclical pattern to prevent the body’s weight from resting on one area too long to prevent pressure ulcers.) Further review revealed an intervention revised 4/9/2025 to “ensure mattress is on soft setting and static feature is not activated.” Review of R5’s “Wound Measurement”, dated 1/13/2025, revealed his left heel wound was healed and he had no other wounds at that time. Review of R5’s “Interdisciplinary Documentation” note, dated 1/30/2025 at 3:36 PM, revealed a new open area on his sacrum measuring 0.8 by 0.6 by 0.1 cm. Review of R5’s “Interdisciplinary Documentation” note, dated 2/3/2025 at 5:45 PM, revealed R5’s coccyx wound was significantly worsening, and Clinical Care Coordinator (CCC) “F” was notified. Review of R5’s “Interdisciplinary Documentation” note, dated 2/19/2025 and documented by former CCC/Wound Nurse “F”, revealed “…(R5) treated for wound infection with cephalexin (anti-biotic) …Wound occurred from unfavorable mattress setting…” Review of R5’s “Wound Measurement” documentation during this time frame revealed: (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2/4/2025- Coccyx pressure- 8.5 by 5.0 by 0.2 cm, stage IV Left buttock blister- 4.0 by 2.0 cm, stage II Right scapula pressure- 11.2 by 9.0 cm, suspected deep tissue injury Left heel pressure- 7.4 by 6.0 cm, suspected deep tissue injury “…New orders placed for daily cares, confirmed air mattress on correct settings…” 2/10/2025- Coccyx pressure- 10 by 14.5 cm, stage IV Right scapula pressure- 4 by 3.8 by 0.2 cm, stage II Left heel pressure- 2.4 by 3.5 cm, suspected deep tissue injury “…buttock wound merged with coccyx wound…” 2/19/2025- Coccyx pressure- 8 by 5 by 4 cm, stage IV Left buttock pressure- 3 by 3 by 0.1 cm, stage II Right scapula pressure- 3 by 2.6 by 0.1 cm, stage II Left heel pressure- 2.6 by 3.6 cm, suspected deep tissue injury In a telephone interview on 9/10/2025 at 2:50 PM, former CCC/Wound Nurse “F” reported she performed an investigation when she was informed of R5’s new wounds and found that his APM mattress was in static mode (a setting where the mattress maintains a firm, constant pressure rather than the usual cyclic inflation and deflation of air cells). Former CCC/Wound Nurse “F” reported she could not confirm how long the bed had been in static mode and staff were educated to ensure that the bed was not left in static mode in the future. In in interview on 9/11/2025 at 8:15 AM, Regional Nurse “A” reported she completed an audit on the air mattresses in the facility on 2/4/2025 when R5’s APM mattress was found to be in static mode. Regional Nurse “A” reported R5’s mattress should always be left in alternating mode and not in static mode, according to his individualized care plan. R5’s Treatment Administration Record (TAR) was reviewed. Undocumented wound treatments in August 2025 were discussed, as well as incorrectly ordered frequency of dressing changes (scheduled too often in some cases). Regional Nurse “A” reported dressings should be performed as ordered, with no missing documentation. Regional Nurse “A” reported treatments should not be completed more often than ordered, as this can also cause wounds to worsen. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R5’s August 2025 TAR revealed: “Apply border foam dressing to right knee for skin breakdown preventative. Change every 5 days”- Dressing documented as completed on 8/1/25, 8/2/25, 8/3/25, 8/4/25, 8/5/25, 8/6/25, 8/11/25, 8/12/25, 8/16/25, 8/18/25, 8/19/25, 8/20/25, and 8/21/25 (more often than every 5 days). “Coccyx: cleanse with (normal saline), soap and water, or wound cleanser, apply calcium alginate dressing (cut to size), cover with nonstick telfa and foam every day shift for wound care”- Undocumented dressing changes on 8/17/25, 8/22/25, 8/24/35, and 8/25/25. “Coccyx: cleanse with (normal saline), soap and water, or wound cleanser, apply wet to dry dressing, cover with abd secure with paper tape every day shift for wound care”- Undocumented dressing changes on 8/1/25, 8/3/25, 8/7/25, 8/8/25, 8/9/25, 8/10/25, 8/13/25, 8/14/25, and 8/15/25. Review of facility policy/procedure “Skin at Risk Assessment: Documentation, Staging, & Treatment”, revised 1/2020, revealed “…It is the policy of this facility to assess resident risk factors for the development of impaired skin integrity and intervene as indicated utilizing the admission assessment, plan of care, and Minimum Data Set as formal assessment tools. It is the policy of this facility to assess skin on a regular basis to determine whether changes in the patient’s skin condition have occurred. Weekly measurements and narrative assessments are conducted on existing pressure injuries…”

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the kitchen resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include:On 9/09/2025 at 11:00AM, during the initial walkthrough, it was observed that there was a resident's personal food item in the Therapy Room refrigerator dated 9/1-9/4. Certified Dietary Manager (CDM) L said that resident's personal food items were not usually stored in the Therapy Room refrigerator, and she noted it was past the use-by date on the sticker. According to the 2022 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . On 09/09/2025 at 1:05PM, two wastewater drain lines were observed draining from the ice machine and the attached ice bin, and the wastewater drain lines did not have air gaps. When asked CDM l indicated that they were unaware that the lines were not air gapped.According to the 2022 FDA Food Code section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed. P

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review the facility failed to implement an effective Infection Prevention and Control Program for a physically compromised Resident (R74) resulting in frequent infections and frequent and aggressive antibiotic therapy without analysis of recurrence, efforts to determine root cause, or actions to ensure proper implementation of infection prevention measures. Findings include:Review of the admission Record reflected R74 originally admitted to the facility 4/12/21 with current diagnoses that included: Chronic Respiratory Failure with Dependence on a Ventilator, Tracheostomy, and Gastrostomy (feeding or peg tube). The medical record reflected R74 also had a nephrostomy catheter. The medical record reflected Enhanced Barrier Precautions (EBP. An elevated level in the use of personal protective equipment) during high contact resident care.Review of the Electronic Medical Record (EMR) revealed a history of frequent infections with antibiotic therapy and included:April 2025The EMR reflected in April R74 had received Amoxicillin (an antibiotic) via peg tube for an oral infection. On 4/4/25 Doctor's Orders reflected this was discontinued and changed to intramuscular injections of Rocephin (an antibiotic) for the oral and an added bronchitis infection until 4/9/2025. On 4/16/25 at 7:02 PM the EMR Progress Notes reflected R74 presented with a fever and low oxygen saturation. The EMR Progress Notes on 4/17/25 at 9:21 AM reflected R74 was ultimately admitted to the Intensive Care Unit for treatment of septic shock. The EMR reflected R74 returned from the hospital at 7:00 PM on 4/24/25 and received an additional intramuscular injection of Rocephin for sepsis. May 2025The EMR Progress Note dated 5/4/25 at 11:00 PM reflected R74 had a temperature of 100.7 and had vomited. On 5/5/25 the Doctor's Order reflected the antibiotic Levofloxacin was ordered for five days to treat pneumonia. The EMR Progress Note of 5/14/25 at 11:25 AM reflect R74 had a notable swelling of her right cheek and antibiotic therapy of Amoxicillin had been initiated for an oral infection.June 2025 The EMR Progress Note dated 6/19/25 at 7:49 PM reflected R74 had an elevated temperature the previous day, presented with edema (swelling) in her right lower extremity and a lower than normal blood pressure. The EMR reflected lab work and a chest x-ray was ordered. The Medication Administration Record (MAR) for June 2025 reflected on 6/19/25 R74 received an intramuscular injection of Ertapenem (antibiotic) and started Amoxicillin for ten days due to an elevated white blood cell count (an indicator of an infection). The medical record reflected on 6/27/25 another chest x-ray was completed on R74, and antibiotic therapy was escalated to intramuscular injections of Cefepime for leukocytosis (elevated white blood cell count) and bilateral lung opacities for seven days. Additionally, an increased dose of the diuretic Lasix from 20 milligrams (mg) to 40 mg was initiated. The antibiotic intramuscular injection continued through 7/3/25.July 2025Review of the EMR Progress Notes of R74 reflected on 7/16/25 at 10:15 AM large amounts of yellow/green secretions were removed from the Residents airway. On 7/18/25 at 1:47 AM the Progress Notes reflected R74 again was suctioned of large amounts of yellow/green sputum, had increased work of breathing, a respiratory rate over forty breaths per minute, oxygen saturation levels in the 70 percent range and a heart rate over 130 beats per minute. The next Progress Note documented approximately one hour later at 2:46 AM reflected that R74 had been to and returned from the hospital. The documentation reflected that R74 had been diagnosed with pneumonia and an elevated white blood cell count. Antibiotic therapy of Levofloxacin for seven days with concurred orders for Zithromax for six days. Furthermore, a topical antifungal for an apparent fungal infection was ordered to be applied to the Resident's neck. The EMR reflected Interdisciplinary Documentation on 7/18/25 at 10:30 AM summarized that the condition of R74 meets the criteria for Loeb and McGeer (infection control tools used to determine an infectious process) and concluded R74 had a respiratory infection. This documentation reflected that the Resident was on a ventilator . had an increase of secretions and decreased (oxygen saturation levels) and termed these symptoms as the Root cause. The extent of the post-incident analysis involved medications were reviewed and the Resident would be monitored. August 2025Review of the medical record for R74 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	reflected on 8/11/25 the antibiotic therapy of Amoxicillin was initiated for oral infection for 10 days. September 2025Review of the medical record for R74 reflected a Doctor's Order on 9/6/2025 for treatment of a urinary tract infection (UTI) with intramuscular injections of ceftriaxone. This was discontinued on 9/9/25 and was changed to an intramuscular injection of Ertapenem (antibiotic) for five days. In summary, since April of 2025 R74 was admitted to the hospital for treatment of septic shock, treated with three antibiotics for an elevated white blood count of undetermined origin, one urinary tract infection, treated three times for pneumonia/bronchitis, and three times for oral infections with 14 antibiotics. Over this period the medical record reflected one root cause analysis that determined secretions and low oxygen levels were the root cause. No documentation was found in the medical record that reflected a review was conducted to ensure Enhanced Barrier Precautions were implemented. No documentation was identified that proper care of the peg tube and nephrostomy catheter were verified, or that sterile technique was executed with tracheotomy care, suctioning and oral care.In an interview conducted with 9/11/25 at 10:48 AM, Infection Preventionist (IP) E reported he assumed the role of IP on 7/2/25. IP E reported he had not detected any pattern of infections or antibiotic use and had not noted that anything had stuck out regarding the care of R74. IP E reported he had been to one monthly Quality Assurance meeting since assuming the role and did not indicate the collective infection and antibiotic use history had been reviewed. A review was conducted of the provided policy titled Infection Prevention and Control Plan, last reviewed by the facility 2/25/25. The policy reflected Policy: It is the policy of this facility to implement the Infection Prevention and Control Program utilizing . (established regulations) pertaining to infection control. The policy reflected 1, The infection control committee incorporates. on an ongoing basis .Surveillance, prevention and control of infections throughout the facility.Selects and implements the evidence-based processed to minimize adverse outcomes.Continually evaluates and monitors the results and presents recommendations for revision to policies and techniques. 2. Surveillance includes (Healthcare Acquired Infections - HAI's) among.residents. Infections are monitored when a treatment plan is ordered by a Health Care Practitioner.c, A collaborative corrective action plan is formulated when surveillance and/or evaluation detects an area of concern or opportunity for improvement.d. The Infection Prevention Manager (IP) assumes direct accountability for the surveillance, aggregation, and analysis of the data.e. Surveillance data may prompt auditing of specific procedures and/or a thorough infection control assessment.3. Targeted analysis will be conducted that are high risk. 4. Monitoring and evaluation of key performance aspects of infection control through preventing, identifying, reporting, investigating and controlling infections.8. Infection prevention is a multi-disciplinary activity with collaboration amongst departments to identify any HAI trends or patterns that may occur or opportunities to improve outcomes in the reduction ad control of infections.10. Confirmed infections are evaluated to assure proper implementation of blood and body fluid barriers. 11. A Departmental infection control inspections are completed and designated monthly.13. Monitoring is achieved through. i. Implementation of infection control practices for resident care such as urinary catheter care, wound care, IV care, incontinence care, respiratory care, dialysis or other invasive treatment.On 9/11/25 at 11:14 AM, an interview was conducted with the Director of Nursing (DON) and Regional Nurse A in the office of the DON. The DON acknowledged that three IP's held the position from April to July 2025. The DON indicated that the interim IP in May and June 2025 was in a corporate position and was onsite weekly or every couple of weeks. The DON was informed of the prevalence of infections and antibiotic treatment of R74 since April 2025. The DON was asked if she was aware of these and if the totality of these infections and treatment had been discussed in Quality Assurance meetings. The DON and Regional Nurse A indicated this would be reviewed.On 9/11/25 at 12:12 PM Regional Nurse A reported that since May of 2025 skin infections were reviewed at Quality Assurance meetings.As of survey exit, no additional information had been provided on the care and treatment of R74 from April to September 2025. No additional information was provided that concerned the implementation of the Infection Prevention and Control Plan consistent with facility policy.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure a qualified Infection Preventionist was in place to properly maintain, manage, and monitor the Infection Prevention and Control Program. Findings include: Review of the document provided by the facility reflected Infection Preventionist (IP) E was awarded an IP certification on 7/2/2025.On 9/11/2025 at 11:14 AM an interview was conducted with the Director of Nursing (DON) in her office. The DON reported, due to a staff vacancy, prior to 7/2/2025 an interim IP was in place. The DON later reported the previous IP left the position on 4/26/2025. The DON indicated an interim IP at the corporate level was in place from 4/26/2025 until 7/2/2025. The DON reported the interim IP monitored the Infection Prevention and Control Program from afar. The DON reported the Interim IP was in weekly or every couple of weeks. The DON reported she was not certain of the interim IP's schedule. As of survey exit no additional information was provided by the facility.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow standards of practice during medication administration for three residents' (Resident #29, Resident #67, and Resident #58) out of 17 residents reviewed. Findings: Resident #67 (R67) Review of an admission Record revealed R67 was a [AGE] year-old female, admitted to the facility on [DATE]. Review of R67’s “Order Summary” dated 2/2/22 revealed, “Ultram Tablet 50 MG (traMADol HCl) .Give 1 tablet by mouth every 6 hours as needed for pain.” Review of R67’s “Controlled Drug Receipt/Record/Disposition Form” revealed that on 8/4/25 a dose of Ultram was dispensed at 5:08 AM and again at 8:04 AM. (Approximately 3 hours apart). Review of R67’s August “Medication Administration Record” confirmed that the doses of Ultram were administered at 5:08 AM and 8:04 AM. During an interview via email on 09/11/2025 at 4:23 PM, Regional Nurse Consultant (RNC) “A” confirmed R67’s Ultram was administered 3 hours apart which did not follow the providers order of every 6 hours. RNC “A” stated, “We filled out a medication discrepancy for the tramadol (Ultram) given too soon and we are doing education with the nurse.” Resident #29 (R29) Review of an admission Record revealed R29 was a [AGE] year-old-male, admitted to the facility on [DATE], with pertinent diagnoses of respiratory failure requiring a tracheostomy and dependence on a ventilator and muscular dystrophy. Review of a Physician Order Summary (POS) for R29 reflected an order for Ativan (an anti-anxiety medication and controlled substance) 0.5 mg (milligrams) one tablet by mouth three times a day. The POS also reflected an order for Morphine Sulfate (a pain reliever and controlled substance) 15 mg one tablet every 12 hours. Review of an Electronic Medication Administration Record (Emar) for R29 dated September 2025 revealed documentation that R29 received three doses of Ativan on 9-7-25. Review of a Controlled Drug Receipt/Record/Disposition Form (CDRRDF) reflected documentation that only two doses of Ativan 0.5 mg were signed out on 9-7-25 for R29. Further review of the Emar for R29 revealed documentation that on 9-7-25, the resident received two doses of Morphine 15mg. Review of the CDRRDF for R29 revealed that only one dose was signed out on 9-7-25. During an interview on 09-10-25 at 1:45 PM, the Director of Nursing stated that documentation on the Emar and CDRRDF's must match because that was the process used to reconcile controlled substances. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #58 (R58) Review of the admission Record reflected R58 originally admitted to the facility 10/21/2016 with a pertinent diagnosis of Diabetes Mellitus. Review of the medical record for R58 reflected current Doctor’s Orders for insulin to be administered from the Novolog FlexPen and a Lantus SoloStar pen injector. Review of the manufacturer’s instruction for the Novolog FlexPen reflected that after attaching a new needle onto the device the instructions reflect “Giving the airshot before each injection…Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: …E. Turn the selector to select 2 units (see diagram…) F. Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your fingers a few times to make any air bubbles collect at the top of the cartridge (see diagram…) G. Keep pointing the needle upwards, press the push-button all the way in (see diagram…) The dose selector returns to 0. A drop of insulin should appear at the needle tip, If not, change the needle and repeat the procedure no more than 6 times. If you do not see a drop of insulin after 6 times, do not use the Novolog FlexPen”. The instructions reflect if a drop of insulin does appear the user may proceed to set the dose selector to the required number of units and continue the administration process. Review of the manufacturer’s instructions for the Lantus SoloStar pen reflect a similar process as above and the user is to “Always perform the safety test before each injection” and “Do not select a dose or press the injection button without a needle attached”. The instructions reflect the safety test ensures an “accurate dose”, …” that pen and needle work properly” and removes “air bubbles”. The safety test requires selecting a dose of 2 units, tapping the device and ensuring insulin comes out of the needle tip as previously described. However, the Lantus SoloStar reflects two unsuccessful repeat attempts may indicate the device, or needle is “damaged” and to not use. On 9/10/2025 at 7:23 AM a medication administration observation and interview were conducted with Registered Nurse (RN) “I”. RN “I” was observed preparing two insulin pens for administration to R58. RN “I” was observed applying new needles to a Novolog Flexpen and a Lantus Solostar pen injector. RN “I” then dialed each pen to dispense the prescribed dose of insulin from each device when administered. RN “I” was asked if any preparation of the pen was required prior to dosing and administration. RN “I” stated, “No need, it has the volume”. Following administration of both insulins from the respective devices RN “I” was again asked if the insulin devices required any preparation prior to use. RN “I” stated “No”. On 9/10/2025 at 12:43 PM at interview was conducted with RN “I” at the nurse’s station. RN “I” reported she had reviewed the instructions on the use of insulin pens and had identified that the pens must be primed prior to use for administration. RN “I” stated “I didn’t know”. The document titled “Medication Administration” “Policy 5.3.9A Insulin Administration” effective 6/21/2017 provided by Regional Nurse “A” was reviewed. The document reflected “Procedure…2. There are also several insulin devices on the market, it is essential that the nurse is also familiar with the device prescribed. Always follow the manufacturer’s instructions .”.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to provide a safe, functional and sanitary environment resulting in an increased potential for contamination of the water supply and a possible decrease in safety for all residents: Findings include: On 9/9/2025 at 2:50PM, observed, in Hall 100 shower room, there was a call light cord wrapped around the handrail next to the toilet. Environmental Services Manager (ESM) M indicated the cord was not supposed to be wrapped around the handrail. On 9/9/2025 at 3:08PM, observed, in Hall 300 soiled linen room, the atmospheric vacuum breaker (AVB) on the sprayer line began spilling water when the foot pedal for the sprayer was engaged. ESM M was not aware the AVB was not working correctly.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to determine a resident as safe to self-administer medication for 1 resident (R73) of 2 residents reviewed for self-administration of medication. Findings include:Review of an admission Record revealed R73 admitted to the facility on [DATE] with pertinent diagnoses which included cerebral infarction and cognitive communication deficit (difficulty with effective verbal and nonverbal communication, stemming from impairments in cognitive functions like attention, memory, reasoning, and problem-solving). Review of R73's Self-Administration of Medication assessment, completed upon admission on [DATE], revealed R73 was deemed unsafe to self-administer medication. Further review revealed .The resident is able to identify the medications prescribed & verbalize knowledge of potential side effects.No.The resident is capable of getting medication out of the locked drawer.No.The resident has demonstrated the capability of asking for his/her medications at appropriate times of the day for two days.No. Review of R73's Physician's Orders on 9/10/2025 at 9:00 AM revealed an active order, started 8/7/2025, for Latanoprost (a prescription eye drop used to lower high pressure inside the eye) eye drops, instill 1 drop in both eyes one time a day. Review of R73's nursing Orders Administration Notes revealed the following:8/31/2025- Latanoprost.states she takes them independently at night9/8/2025- Latanoprost.independently administers9/9/2025- Latanoprost.self administers In an observation and interview on 9/10/2025 at 8:41 AM in R73's room, R73 reported her eye drops were in her top drawer and pointed across the room to a drawer on the wall. Two bottles of Latanoprost eye drops were in the drawer. Licensed Practical Nurse (LPN) G reported she was not sure whether R73 had been evaluated as safe to self-administer medication. In an interview on 9/10/2025 at 9:20 AM, the Director of Nursing (DON) reported she was not sure why R73's eye drops were in her room and the facility would re-assess her to determine whether she was safe to self-administer medication. Review of facility policy/procedure Self-Administration of Medication, revised 5/2020, revealed .Each resident has a right to self-administer drugs unless the interdisciplinary team. has determined that this practice is unsafe.Self-Administration is assessed only for those residents who. Have expressed the desire to self-administer. Have demonstrated minimal cognitive, visual, and physical abilities as determined by the interdisciplinary team. Have a written health care practitioner order to self-administer.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2569423Based on interview and record review, the facility failed to ensure facility staff immediately reported an allegation of neglect to the abuse coordinator for 1 resident (Resident #79) reviewed for neglect.Findings:Resident #79 (R79)Review of an admission Record revealed R79 was an [AGE] year-old female, admitted to the facility on from 6/24/25 to 7/17/25.Review of R79's Resident Assistance Form completed by R79's Family Member (FM) C revealed, It was reported to me when I arrived (07/04 ~9:45-10 AM) by (Certified Nursing Assistant [CNA] B) that PT (physical therapy) found mom soaked head to toe (and bed soaked) with urine and that the stench from her room was overwhelming. Her room still smelled when I arrived. PT almost had to cut of mom's clothes to remove them because they were so heavily soaked and clinging to her body.(CNA B) stated that he was told mom's assistant claimed mom refused care. For mom, this cannot be true! Mom is extra conscientious about her toileting and personal care. She was placed in bed, fully clothed, at 3:30 pm on 07/03. She fell asleep and I left @ 4:20 pm. She was still wearing those clothes when she was found by PT and (CNA B) in a urine soaked bed (on 7/4/25).Further review of the Resident Assistance Form revealed a handwritten note RECEIVED UNDER DOOR 7/7/25 REVIEWED AT 11AM. (3 days following the alleged neglect was identified).Review of the Facility Reported Incident (FRI) investigation revealed: Date/Time Incident Discovered: 7/7/2025 11:00 AMDate/Time Incident Occurred: 7/4/2025 07:00 AM.Allegation Details: Family member (daughter) completed a Resident Assistance Form and left under Administrators office door on 7/4/2025 along with other papers put there over the weekend and wasn't identified until 11:00am on 7/7/2025. The Assistance Form revealed an allegation of neglect for not being provided with incontinence care from the night of 7/3/2025.Review of CNA B's Witness Statement dated 7/11/25 revealed, (CNA B) reported to (FM C) on 7/4/2025 that Me and the therapist discovered (R79) soaked in urine. I explained the measures we took to clean her up. I found it strange because she always requests the bed pan. (FM C) expresses to her that this is bullshit she is a mandated reported and will be reporting it and I told her I was also reporting it to (Director of Nursing [DON]). (CNA B) did not report to (DON) he expressed his concerns to (Licensed Practical Nurse [LPN] D) the Charge nurse.On 7/14/2025 at 3:55pm a Clarification interview with (CNA B) revealed he did feel it was neglectful at the time. CNA B did not immediately notify the abuse coordinator at the time he identified the alleged neglect.Review of LPN D's Witness Statement dated 7/7/25 revealed, .(LPN D) was not called into the room to witness or assess the resident at the time staff discovered she was very wet. She states she was notified 2 hours into the shift the resident was very wet and explained she did not refuse care on the last rounds from nights. LPN D did not immediately notify the abuse coordinator at the time she was notified of the alleged neglect.During an interview on 09/11/2025 at 9:45 AM, the Nursing Home Administrator (NHA) reported that all staff are educated on the regulations of abuse reporting upon hire and during ad-hoc facility in-services. Review of CNA B's employee file confirmed completed education on abuse reporting in October 2024.During an interview on 09/11/2025 at 11:54 AM, R79's FRI investigation was reviewed with NHA. NHA confirmed that CNA B had not immediately reported the alleged neglect to the abuse coordinator per the facility policy and federal regulations and reported that there was no PNC (past noncompliance) completed regarding the deficient practice.Review of the facility policy Abuse Prevention Overview last revised March 2019 revealed, .1. Alleged incidents are reported immediately to the facility administrator and to the State Agency as required and outlined in the facility policy for reporting abuse.Review of the facility policy Abuse/Suspected Abuse; Crime Investigation & Reporting last revised February 2023 revealed, .2. Any person(s) witnessing or having knowledge of potential or actual abuse or crime must immediately report the incident to the Administrator and / or designee. In the case of a resident or family member, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	such a report can be made to the charge nurse or person assigned to receive complaints, who is responsible to follow through with reporting procedures. 3. When allegations of resident (S483.5) mistreatment, abuse, crime, neglect, exploitation, misappropriation, or injuries of unknown source are reported, the administrator and designees will investigate the allegation with the assistance of appropriate personnel.

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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 interview and record review the facility failed to honor bathing preferences for one resident (R39). Findings include:Review of the admission Record reflected R39 originally admitted to the facility 7/1/2022 with current pertinent diagnoses that included infection and inflammatory reaction due to internal right knee prothesis, polyneuropathy (a disease affecting peripheral nerves and features weakness and burning pain), and need for assistance with personal care. Review of the Minimum Data Set (MDS) dated [DATE] reflected R39 was cognitively intact and required partial/moderate assistance with transfers from bed to chair and to get in and out of a tub or shower.During an interview conducted on 9/9/2025 at approximately 10:45 AM, R39 reported he did not take showers because the beating of the water from the shower was too painful. R39 reported his last shower was about six months ago and has had only bed baths since then. R39 reported bed baths are not the same. R39 reported he had been offered a jacuzzi bath (whirlpool tub) but has not had any because no one knows how to use it.The Care Plan titled Altered functional mobility and ADL's (Activities of Daily Living) related to weakness. initiated 10/17/2023 was reviewed. Under Interventions for this Care Plan revealed Bathing: One person assist with bathing, encouraging the resident to do as much as for self as able. (R39) prefers bed baths only for comfort. Encourage whirlpool tub bathing experience initiated 10/17/2023 and revised 4/18/2025.On 9/10/2025 at 1:04 PM, the Director of Nursing (DON) reported she believed the whirlpool tub was operational. The DON was informed that the Care Plan reflected that R39 was to be encouraged to use the whirlpool tub but that R39 had been told by staff they do not know how to use it. The DON reported she believed that the Peer Mentors were to be the trainers on the use of the whirlpool.On 9/10/2025 at 12:51 PM Certified Nurse Aide (CNA) K reported she had showered residents but did not know how to use the whirlpool tub.On 9/10/2025 at 1:57 PM CNA N reported she had given residents showers but had never used the whirlpool tub.

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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 provide tracheostomy care using sterile technique for one of three resident's (Resident #74) reviewed. Findings:Resident #74 (R74) Review of an admission Record revealed R74 was an [AGE] year-old female, last admitted to the facility on [DATE], with pertinent diagnoses of Parkinson's Disease, Alzheimer's, and a tracheostomy and ventilator dependent. During an observation on 09-09-25 at 11:45 AM, Registered Nurse (RN) P provided trach care to R74 which included replacing the inner cannula. RN P did not don sterile gloves to handle and place the inner cannula into the tracheostomy and while placing the sterile inner cannula, touched the flange of the outer cannula. During an interview on 09-09-25 at 1:46 PM, Respiratory Therapist (RT) O stated that trach care was completed twice daily and replacing the inner cannula was done utilizing sterile technique. During an interview on 09-10-25 at 8:45 AM, the Director of Nursing and the Regional Clinical Support Nurse stated that replacing the inner cannula when nurses performed tracheostomy care was completed with sterile technique.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to effectively communicate and coordinate resident care with hospice for one resident (R5) of 1 resident reviewed for hospice. Findings include: Review of an admission Record revealed R5 admitted to the facility on [DATE] with pertinent diagnoses which included dementia and complete paraplegia (loss of motor and sensory function). Review of R5's active Physician's Orders, revised 2/17/2025, revealed .Hospice to Eval and treat. Review of a current end of life Care Plan intervention for R5, revised 2/24/2025, revealed .Hospice has been elected and the facility & hospice will coordinate care & services. Review of R5's Electronic Medical Record (EMR) on 9/10/2025 at 1:58 PM revealed no hospice notes uploaded since the middle of August 2025. In an interview on 9/11/2025 at 9:39 AM, undocumented treatments of dressing changes on the Treatment Administration Record (TAR) were discussed with the Director of Nursing (DON) and Regional Nurse A. The DON reported some of the dressing change undocumented treatments on the TAR could be times when the hospice nurse changed the dressing. Regional Nurse A reported whether the hospice nurse or the facility nurse changed the dressing, the EMR should reflect the completion of the dressing change and there should be no undocumented treatments. Review of Hospice Registered Nurse (RN) Visit Note Report for R5, dated 8/28/2025, revealed .redness noted to back of (left) knee and top of (right) ankle, notified floor nurse, collaboration of care completed with (Clinical Care Coordinator (CCC) J) . Further review of the EMR revealed no documentation that these skin concerns were assessed or followed up by facility staff. In an interview on 9/11/2025 at 11:12 AM, the DON reported facility staff should have assessed the new areas of skin concern identified by the hospice nurse on 8/28/2025, documented an assessment, and initiated appropriate follow up. CCC J reported she responded to the conversation with the hospice nurse on 8/28/2025 by repositioning R5. CCC J reported she did not know whether the areas of redness identified by the hospice nurse were blanchable (skin that turns white or pale when pressed and returns to its original color indicating blood flow to the area) and she did not document an assessment of the skin concerns. Review of Hospice Licensed Practical Nurse (LPN) H Visit Note Report for R5, dated 8/21/2025, revealed identification of a new right heel unstageable deep tissue injury. Further review of the documentation revealed no clarification of whether this new wound was discussed with facility staff. Review of a hospice order written by Hospice LPN H on 8/21/2025 revealed .Cleanse with wound cleanser, pat dry wipe with skin prep wipe and apply heel foam cup. Further review of the EMR did not show any documentation the facility was aware of this new wound. Review of the TAR revealed no documentation this right heel wound dressing was completed by the facility. In an interview on 9/11/2025 at 12:59 PM, Hospice LPN H reported she discussed the new right heel deep tissue injury with the facility floor nurse and the facility Nurse Practitioner (NP) when she identified the wound on 8/21/2025. Hospice LPN H reported the facility NP instructed her to write an order for the dressing change. Hospice LPN H reported she was not aware whether R5 had a hospice binder to communicate with the facility. In an interview on 9/11/2025 at 11:12 PM, the DON reported the facility should be writing the orders for dressing changes and not hospice, and hospice should be following the facility orders. No documentation could be found that the facility was aware of R5's new right heel wound or that the hospice dressing order was completed by facility staff. R5's hospice binder was viewed and the last Hospice and Facility Coordinated Plan of Care was dated February of 2025 and the last time hospice staff had used the Sign in Log was 6/16/2025. The DON reported the Hospice and Facility Coordinated Plan of Care is updated quarterly and the up-to-date copy should be in the hospice binder. In an interview on 9/11/2025 at 1:21 PM, the DON acknowledged communication between the facility and hospice for R5 needed to improve. The DON reported the facility was unaware they had not received the last 30 days of hospice notes until this surveyor had requested them that day. Review of (continued on next page)

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	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gladwin Pines Nursing and Rehabilitation Center	449 Quarter Street 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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policy/procedure Hospice Care, Revised 6/2018, revealed .The plan of care will reflect the residents' current medical, physical, psychosocial, and spiritual needs. Hospice will reflect these coordinated services on the facilities template for the plan of care within the medical record. The plan of care will reflect which services are provided by the nursing facility and which are provided by hospice. The facility and hospice are responsible for performing their respective functions, which have been agreed upon and included in the jointly developed Plan of Care.