STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115025	A. Building B. Wing	01/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Health Center by Harborview	4115 Glenwood Rd Decatur, GA 30032

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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 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. Based on record review, facility document review, interviews, and a review of the facility policy titled Abuse, Neglect and Exploitation, the facility failed to report allegations of abuse to the state survey agency within two hours for two of five incidents (the incident involving R34 and the incident involving R208) of abuse reviewed.Findings included:A review of the facility policy titled Abuse, Neglect and Exploitation, last reviewed 7/15/2025, indicated, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The policy revealed, IV. Identification of Abuse, Neglect and Exploitation, included, B. Possible indicators of abuse include, but are not limited to, which included, 1. Resident, staff or family report of abuse; 2. Physical marks such as bruises or patterned appearances such as handprint, belt or ring mark on a resident's body; and 3. Physical injury of a resident, of unknown source. The policy revealed, VII. Reporting/Response included, A. The facility will have written procedures that included, which included, 1. Reporting of all alleged violations, regardless of residents [sic] cognitive status, to the Administrator, state agency, adult protective services, physician, responsible parties, law enforcement (when applicable, regardless of cognitive status) and to all other required agencies within specified timeframes, which included, a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury.1. A review of the admission Record indicated the facility admitted R34 on 5/1/2024. According to the admission Record, the resident had a medical history that included diagnoses of stroke, traumatic brain injury (TBI), major depressive disorder, and anxiety disorder.A review of the quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 11/11/2025, revealed R34 had modified independence in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS).A review of the Facility Incident Report Form, dated 12/22/2025 and completed by the Administrator (ADM), indicated that the facility reported an incident involving R34 that occurred on 12/22/2025 to the state survey agency. The report revealed Other was selected under Type of Incident. The report indicated that R34, who was non-verbal, pointed at their genitalia, then pointed at Certified Medication Aide (CMA)12. Per the report, the CMA was immediately suspended, and an investigation was initiated. The report revealed that the Date and Time of Incident revealed the date (12/22/2025) but did not list the time of the incident.A review of the facility's Exception Report, dated 12/22/2025 at 10:35 pm, revealed the incident involving R34 occurred on 12/22/2025 at 7:00 pm.A review of the facility's investigation documents included an email response from the state agency to the ADM, dated 12/22/2025 at 10:18 pm, that indicated the state agency had received the facility's initial report, over three hours after the incident occurred.During an interview on 12/31/2025 at 3:31 pm, Licensed Practical Nurse (LPN)9 stated they were made aware of the allegation (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	involving R34 by Receptionist28. LPN9 stated they were told that R34 motioned as though they had been sexually assaulted. LPN9 stated that they got Unit Manager (UM)22 to help with the investigation. LPN9 stated that the ADM was on the phone with them and UM22 while R34 was interviewed. LPN9 stated that allegations of abuse should be reported to the state survey agency within two hours.During an interview on 1/2/2026 at 12:07 pm, LPN9 stated they were not sure what time the allegation was made by Receptionist28.During an interview on 1/2/2026 at 12:18 pm, UM22 stated that LPN9 came to them at around 6:00 pm, reported an allegation of abuse, and asked for help with it being their first one to initiate. UM22 stated she and LPN9 went to R34's room to interview them and collect more information. UM22 stated that was unsure of the time it was reported to the ADM, who was the Abuse Coordinator, but knew it was shortly after they went to interview the resident because the ADM was on speaker phone with them and R34. UM22 stated that all allegations should be reported to the state survey agency within two hours of notification.During an interview on 1/2/2026 at 4:45 pm, Receptionist28 stated that R34 approached them in the hallway by the dining room entrance around 4:30 pm to 5:00 pm. Receptionist28 stated R34 gestured at their private area, grunted, and pointed at the [NAME] Hall nurse station. Receptionist28 stated that the resident's face was red, and they tried to get a point across. Receptionist28 stated that at 6:40 pm, she reported it to a nurse. Receptionist28 stated that she did not report it right away because she was unsure of what to do and did not know what the resident said.During an interview on 1/3/2026 at 9:01 am, the Director of Nursing (DON) stated that allegations of abuse were to be reported by staff immediately. He stated that they had two hours to report it to the state survey agency if it was physical, verbal, mental, or sexual abuse. He stated that he expected any allegation of sexual abuse to be reported within two hours of the facility staff becoming aware of the allegation.During an interview on 1/2/2026, the ADM stated that when a report was submitted to the state survey agency, they automatically received an email indicating that it was received.During an interview on 1/3/2026 at 9:14 am, ADM stated that any allegation or incident of abuse, such as physical, verbal, mental, or sexual, should be reported immediately and then reported to the state survey agency within two hours. She stated that she expected any allegations or incidents of abuse to be reported to the state survey agency within two hours. 2. A review of the admission Record revealed the facility admitted R208 on 4/17/2020. According to the admission Record, the resident had a medical history that included diagnoses of type 2 diabetes mellitus and chronic kidney disease.A review of the quarterly MDS assessment, with an ARD of 6/23/2025, revealed R208 had a BIMS score of 5, which indicated the resident had severe cognitive impairment. The MDS indicated R208 did not have psychosis, physical or verbal behavioral symptoms, or rejection of care.A review of R208's Care Plan Report included a focus area, initiated 4/29/2020, that indicated the resident had an Activities of Daily Living (ADL) self-care performance deficit related to dementia, limited mobility, and cellulitis. The focus area also indicated R208 was blind and was new to the facility. Interventions directed staff to provide assistance with transfers, bed mobility, dressing, personal hygiene, bathing, incontinence care/toileting, eating, and locomotion on and off the unit as needed (revised 3/6/2022).A review of the Facility Incident Report Form, dated 8/12/2025, indicated R208's Family Member (FM30) reported that per the MD [medical doctor] at the hospital, [R208] has a subdural hematoma [bleeding on the brain] which could have been caused by a fall or a strike to the head.A review of an untitled facility investigation document, dated 8/17/2025, revealed in the section Incident that On Monday, (8/11/2025), [FM30] came to the facility and stated that the doctor in the hospital stated that [R208] has a subdural hematoma and it might be from a fall or a strike to the head. The section Conclusion revealed that the allegation was unsubstantiated. The investigation was signed by (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the ADM.During an interview on 1/2/2026 at 3:43 pm, the DON stated his expectation was that when a resident exhibited an injury of unknown origin was to report it to the state within two hours.During an interview on 1/3/2026 at 8:50 am, the ADM stated her expectation was that when a resident exhibited an injury of unknown origin, it was to be reported to the state within two hours.During an interview on 1/3/2026 at 10:36 am, the ADM reviewed R208's investigation that she submitted to the state and stated it was accurate. The ADM stated that the DON reported to her that the family reported to the facility on 8/11/2025, and she did not report to the state until 8/12/2025. The ADM stated the allegation should have been reported to the state within two hours of the facility being made aware of the allegation.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. Based on record review, facility document review, interviews, and a review of the facility policy titled Abuse, Neglect and Exploitation, the facility failed to thoroughly investigate and failed to maintain accurate documentation of investigations of abuse for four of the five (incident involving R97 and R176; incident involving R34 and Certified Medication Assistant(CMA)12; incident involving R59 and R194; and incident involving R171 and Certified Nursing Assistant(CNA)13) abuse allegations reviewed.Findings included:A review of the facility policy titled Abuse, Neglect and Exploitation, last reviewed 7/15/2025, indicated, It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The policy revealed, V. Investigation of alleged Abuse, Neglect and Exploitation included, A. An immediate investigation is warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occur. The policy continued, B. Written procedures for investigations included, which included 5. Focusing the investigation on determining if abuse, neglect, exploitation, and/or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation.1. A review of the admission Record indicated the facility admitted R176 on 3/29/2025. According to the admission Record, the resident had a medical history that included a diagnosis of unspecified injury at an unspecified level of cervical spinal cord, subsequent encounter.A quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/26/2025, revealed R176 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident did not exhibit behavioral symptoms directed toward others during the assessment timeframe.A review of the admission Record included the facility admitting R97 on 5/28/2025. According to the admission Record, the resident had a medical history that included a diagnosis of nontraumatic intracerebral hemorrhage, intraventricular.A review of the annual MDS, with an ARD of 11/11/2025, revealed R97 had a BIMS score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident did not exhibit behavioral symptoms directed toward others during the assessment timeframe.A review of the Facility Incident Report Form, dated 11/13/2025 and completed by the Administrator (ADM), indicated that the facility reported a Resident to Resident incident that occurred that day between R97 and R176. The document indicated that it was reported that R176 spat on R97, then R97 struck R176. The Facility Incident Report Form indicated that the residents were separated and that an investigation was initiated. The report revealed that the Date and Time of Incident revealed the date (12/22/2025) but did not list the time.A review of a typed statement, dated 11/13/2025 and signed by the Director of Nursing (DON), indicated that on 11/13/2025 at 11:00 am, the DON heard commotion and when he went to the hallway to check, R97 was alleging that R176 had spit on them (R97). The statement indicated that R176 stated that R97 had hit them (R176). The statement indicated that the DON witnessed spit on R97's shirt. Per the statement, the residents were separated. The statement did not indicate when the ADM, who was the Abuse Coordinator, was notified of the incident.A review of R97's Exception Report, dated 11/13/2025, indicated that the incident between R97 and R176 occurred on 11/13/2025 at 1:05 pm (in contrast with the DON's typed statement and the time the initial report was made).A review of R176's Exception Report, dated 11/13/2025, indicated that the incident between them and R97 occurred on 11/13/2025 at 1:21 pm (in contrast with the DON's typed statement and the time the initial report was made).A review of the facility's investigation documents included a typed investigative summary that was addressed to the state survey agency, dated 11/20/2025. The document revealed that it did not list the time the incident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	occurred, nor when the ADM was notified of the incident.2. A review of the admission Record indicated the facility admitted R34 on 5/1/2024. According to the admission Record, the resident had a medical history that included diagnoses of stroke, traumatic brain injury (TBI), major depressive disorder, and anxiety disorder.A review of the quarterly MDS assessment, with an ARD of 11/11/2025, revealed R34 had modified independence in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS).A review of the Facility Incident Report Form, dated 12/22/2025 and completed by the ADM, indicated that the facility reported an incident to the state survey agency involving R34 that occurred on 12/22/2025. The report revealed Other was selected under Type of Incident. The report indicated that R34, who was non-verbal, pointed at their genitalia, then pointed at CMA12. Per the report, the CMA was immediately suspended, and an investigation was initiated. The report revealed that the Date and Time of Incident revealed the date (12/22/2025) but did not list the time of the incident.A review of the facility's investigation documents revealed that they did not indicate when the ADM, who was the Abuse Administrator, was notified of the incident.3. A review of the admission Record indicated the facility admitted R59 on 8/14/2023. According to the admission Record, the resident had a medical history that included diagnoses of major depressive disorder, anxiety disorder, dementia, and other schizoaffective disorders.A review of the quarterly MDS assessment, with an ARD of 9/19/2025, revealed R59 had severe impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a SAMS.A review of the quarterly MDS assessment, with an ARD of 12/23/2025, revealed the facility added R194 on 6/16/2017. Per the MDS, the resident had a BIMS score of 4, which indicated the resident had severe cognitive impairment.A review of the Facility Incident Report Form, dated 11/11/2025 and completed by the ADM, indicated that the facility reported a Resident-to-Resident incident to the state survey agency. The report indicated that it was reported that R59 was slapped by R194. The report revealed that the Date and Time of Incident revealed the date (11/11/2025) but did not list the time of the incident.The facility's investigation documents revealed that they did not include when the ADM, who was the Abuse Coordinator, was informed of the incident.4. A review of the admission Record indicated the facility admitted R171 on 8/9/2023. According to the admission Record, the resident had a medical history that included diagnoses of chronic congestive heart failure, depression, and chronic respiratory failure.A review of the quarterly MDS assessment, with an ARD of 11/11/2025, revealed that R171 had a BIMS score of 15, which indicated the resident had intact cognition.A review of the Facility Incident Report Form, dated 11/24/2025 and completed by the ADM, indicated that the facility reported a Staff-to-Resident incident to the state survey agency. The report indicated that R171 reported that CNA13 was rough with them. The report revealed that the Date and Time of Incident revealed the date (11/24/2025) but did not list the time of the incident.A review of the Exception Report, dated 11/24/2025, related to the incident that occurred involving R171, indicated that the ADM, who was the Abuse Coordinator, reviewed the incident on 11/17/2025 (in contrast with when the incident allegedly occurred).A review of the facility's investigation documents revealed that they did not include when the ADM was notified of the incident.During an interview on 1/3/2026 at 9:01 am, the DON stated that he expected the facility's abuse investigations to be complete and thorough. He stated that he expected the exact date and time the incident occurred to be in the investigation. He stated that he expected the time the Abuse Coordinator was notified to be in the investigation.During an interview on 1/1/2026 at 2:02 pm, the ADM stated she was the Abuse Coordinator. The ADM stated that she expected investigations to include the date and time the incident occurred, and when she was notified.

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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. Based on observation, interview, and a review of the facility policies titled Nail Care and Activities of Daily Living (ADLs), the facility failed to ensure staff provided nail care for one of seven sampled residents (R) (R35) reviewed for ADL care.Findings included:A review of the facility policy titled Nail Care, revised 3/1/2024, revealed that the purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health. The policy revealed: 3. Routine cleaning and inspection of nails will be provided during ADL [activities of daily living] care on an ongoing basis. 4. Principles of nail care: a. Nails should be kept smooth to avoid skin injury. b. Only licensed nurses shall trim or file the fingernails of residents with diabetes. Toenails of residents with diabetes or circulation problems shall be filed only.A review of the facility policy titled Activities of Daily Living (ADLs), revised 7/15/2025, revealed that the facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure that a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care. The policy continued, 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, including assistance and cueing as necessary, while also following the physician's orders and Care Plan with regard to assistive devices, grooming, and personal and oral hygiene. A review of the admission Record revealed the facility readmitted R35 on 10/20/2023. According to the admission Record, the resident had a medical history that included diagnoses of hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting the dominant right side, cerebellar stroke syndrome, type two diabetes mellitus, and major depressive disorder.A review of the annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/19/2025, revealed R35 had a Brief Interview of Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required partial to moderate assistance from staff with personal hygiene.A review of R35's Care Plan Report included a focus area, revised on 1/18/2024, that indicated the resident required assistance with activities of daily living. Interventions directed staff to provide nail care as needed (revised 3/6/2022).During a concurrent observation and interview on 12/29/2025 at 12:53 pm, R35 was outside of the resident's room in a wheelchair. R35's fingernails on the left hand were observed to extend approximately one-half inch past the end of the fingertip, with a yellow tint and brown matter under the fingernails. R35's fingernails on the right hand were observed to extend approximately one-half inch past the end of the fingertip. The resident's fingernail on the middle finger of the right hand was noted to be black, and the fifth fingernail had white discoloration present. R35 stated the staff never asked to cut the resident's nails. R35 stated they wanted the staff to cut their fingernails.During an interview on 12/31/2025 at 10:33 am, Unit Manager (UM)22 entered R35's room and observed R35's fingernails. She stated R35's fingernails were thick and overgrown on the right hand, and the middle fingernail was discolored. She stated R35's fingernails on their left hand needed to be trimmed, but none of the nurses or aides had let her know. UM22 stated that typically, R35 would tell her, and the resident had not. She stated that the staff should have taken care of R35's fingernails.A review of R35's Progress Notes for the timeframe from 12/20/2025 through 12/30/2025 revealed no documented evidence to indicate the resident had refused nail care.During a phone interview on 1/1/2026 at 6:29 pm, Certified Nurse Assistant (CNA)19 said he gave R35 a bed bath on 12/25/2025. He confirmed that he did not clean or trim the resident's nails.During a phone interview on 1/1/2026 at 8:50 pm, CNA17 stated he remembered giving R35 a shower, and when he checked (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	off nail care on the shower sheet, it meant he just cleaned the nails. He stated he did not notice if R35's fingernails needed to be cut. He stated he did not recall R35 saying anything about wanting their fingernails cut.During a phone interview on 1/1/2026 at 8:02 pm, Licensed Practical Nurse (LPN)23, stated that neither R35 nor a CNA told her the resident's fingernails needed to be trimmed. She stated that if R35's nails needed to be trimmed, she expected the aides to tell the nurses. She stated she did not notice R35's nails needed to be trimmed.During a phone interview on 1/2/2026 at 11:33 am, Charge Nurse (CN)24 stated she trimmed R35's nails after it was brought to her attention by UM22. She stated R35's fingernails on the right hand were thick, hard, and black in color. She stated that R35's fingernails on the left hand were overgrown.During an interview on 1/2/2026 at 12:31 pm, the Director of Nursing (DON) stated his expectation was that if a resident were diabetic, podiatry services would trim the resident's fingernails for the resident. The DON stated that if R35 refused nail care, the refusal should be documented in the resident's chart. He stated that when staff completed room observations and gave medications, they were doing an overall observation of the resident, and it should be identified at that time. He clarified and stated that a nurse could trim a diabetic's nails, and if uncomfortable, they could call podiatry services. He stated his expectation for a CNA was to clean the resident's nails when bathing a resident; they were to provide ADL care, and if the fingernails needed to be trimmed, they could do so if the resident was not a diabetic.During an interview on 1/2/2026 at 12:14 pm, the Administrator stated her expectation was that staff should provide nail care for residents who needed it. She stated that staff should provide nail care when providing a shower, if the resident requested it, or as needed.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and a review of the facility policy titled Fall Prevention Program, the facility failed to implement fall interventions to prevent falls for one of two sampled residents (R) (R18) reviewed for falls. Harm was identified to have occurred on 10/28/2025, when R18 sustained a fall, causing a laceration to R18's head, a nontraumatic intracranial (within the skull) hemorrhage (bleeding), and a nontraumatic subarachnoid (fluid-filled space around the brain through which major blood vessels pass) hemorrhage, which required hospitalization.Findings included:A review of the facility policy titled Fall Prevention Program, revised 1/1/2025, revealed that each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The policy revealed:9. When any resident experiences a fall, the facility will: a. Assess the resident; b. Complete a post-fall assessment; c. Complete an incident report; d. Notify physician and family; e. Review the resident's care plan and update as indicated; and f. Document all assessments and actions.A review of the admission Record revealed the facility readmitted R18 on 8/1/2024. According to the admission Record, the resident had a medical history that included a diagnosis of Alzheimer's disease (onset 11/22/2022), fracture of nasal bones (onset 9/20/2025), and nontraumatic intracranial hemorrhage (onset 10/31/2025).A review of R18's Fall incident report, dated 9/19/2025 at 1:01 pm, revealed Licensed Practical Nurse (LPN)3 was taking the resident to the dining room, and the resident leaned forward, fell, and hit their head. The document revealed, Immediate Action Taken indicated R18 sustained a bruise to their forehead, vital signs (measurements including body temperature, heart rate, respiratory rate, and blood pressure that indicate the status of the body's vital functions) were documented, and the resident's family member was notified. The report indicated that interventions included that staff were to ensure R18 was fully back in their wheelchair with their feet on the footrest and clothing/shoes adjusted before transport began.A review of the annual Minimum Data Set (MDS) assessment, with an Assessment reference Date (ARD) of 9/20/2025, revealed that R18 had moderate impairment in cognitive skills for daily decision-making and had short-term and long-term memory problems per a Staff Assessment of Mental Status (SAMS). A review of the MDS revealed that R18 used a wheelchair. The MDS also indicated R18 had one fall with major injury since the prior assessment.A review of R18's Post Fall record, dated 10/28/2025 at 3:52 pm, indicated R18 slid out of their wheelchair to the floor and hit their head as a staff member was taking the resident to their room after lunch. The record indicated R18 experienced pain, had a small size laceration (a cut) to their upper right eye, and had swelling and bruising to the right eye. The record indicated the resident's nurse practitioner was notified, and a new order was received to send the resident to the emergency room for evaluation.A review of R18's Exception Report, dated 10/28/2025 at 4:25 pm, revealed that a fall occurred on 10/28/2025. The record indicated R18 slid out of their wheelchair to the floor when a staff member transported the resident from the cafeteria to their room, resulting in a small hematoma (a collection of blood outside of blood vessels) above the resident's right eye. The record indicated R18 was eating lunch before the event. The record indicated that R18 was sent to the hospital for evaluation and treatment of the hematoma and medication review.A review of R18's hospital Demographics record revealed the hospital admitted R18 on 10/28/2025 with diagnoses that included laceration without foreign body of other part of head, initial encounter; Nontraumatic intracranial hemorrhage, unspecified; and Nontraumatic subarachnoid hemorrhage, unspecified.A review of R18's hospital H&P [History and Physical], dated 10/28/2025 at 10:38 pm, indicated R18 was brought to the emergency department (ED) on 10/28/2025 following a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115025	A. Building B. Wing	01/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Health Center by Harborview	4115 Glenwood Rd Decatur, GA 30032

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 0689 Level of Harm - Actual harm Residents Affected - Few	fall after attempting to stand from their wheelchair. The record indicated R18 had right periorbital ecchymosis and edema (bruising and swelling) around the right eye and a laceration near the right eyebrow, which was repaired in the ED. The record indicated that a computerized tomography (CT) scan of R18's head revealed a trace subarachnoid hemorrhage over the left temporal convexity (left side of the brain). The record indicated neurosurgeons were consulted, who recommended Intensive Care Unit (ICU) admission for close neurological monitoring and a six-hour follow-up head CT. The record indicated that the resident recently fell on 9/19/2025 and fractured their nose. The record indicated R18 was critically ill and required continued critical care treatment.A review of R18's Hospital Medicine Discharge Summary indicated that the hospital discharged the resident back to the facility on [DATE].During an interview on 1/2/2026 at 9:57 am, Certified Nurse Assistant (CNA)1 stated that on the day R18 fell, CNA1 was in the dining room assisting with lunch and assisting residents back to their rooms. CNA1 stated that when she pushed R18 in their wheelchair around the corner and out of the dining room, the resident went face forward to the floor and hit their head (pointing to the right temporal area). CNA1 stated R18 had bruising, swelling, and bleeding in the area. CNA1 stated that when she was pushing R18, the resident had their legs straight out approximately five inches off the floor, and on that day, there were no footrests on the wheelchair. CNA1 stated she did not know who brought R18 to the dining room, but they would have been responsible for putting the footrests on the wheelchair before bringing the resident to the dining room for lunch. CNA1 stated she noticed there were no footrests on the chair when R18 fell out of the chair, but there should have been. CNA1 stated that before the fall, R18 had no swelling or bruising to that area.During an interview on 1/2/2026 at 10:51 am, CNA2 stated she took R18 to the dining room the day the resident fell out of their wheelchair. CNA2 stated R18 was in bed, and she got the resident up with the assistance of another staff member. CNA2 stated she made sure R18 was positioned correctly, and she thought the footrests were on the wheelchair before transporting the resident to the dining room. CNA2 stated that sometimes there were footrests on the wheelchair, but sometimes there were not. CNA2 stated that the footrests should have been on the wheelchair, and they always tried to make sure the footrests were on before transporting the resident in their wheelchair.During an interview on 1/2/2026 at 11:02 am, LPN3 stated she was at the nurses' station when R18 fell out of their wheelchair. LPN3 stated she heard a thud and looked up, and the resident was on the floor in front of their wheelchair with CNA1 at their side. LPN3 stated she ran to assess R18, and the resident had a hematoma and bleeding from a cut on the right side of their head above their eyebrow. LPN3 stated she cleaned the wound and stopped the bleeding by putting pressure on it. LPN3 stated she took R18 to their room and called the ambulance to take the resident to the hospital. LPN3 stated she remembered telling CNA2 to make sure the footrests were on before taking the resident to the dining room. She stated that someone could have taken the footrests off after getting to the dining room so that R18's legs could fit under the table to eat. LPN3 stated the footrests should have been put back on the wheelchair prior to transporting R18 back to their room.During an interview on 1/3/2026 at 1:36 pm, the Director of Nursing (DON) stated that all interventions should be in place before transporting R18 in their wheelchair. The DON stated that if the footrests were removed from the wheelchair after arriving in the dining room, then they should have been put back on before transporting the resident.During an interview on 1/3/2026 at 1:43 pm, the Administrator stated that she expected all interventions to be put in place to prevent future falls with major injuries.