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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interviews, record review, and a review of the facility policy titled Comprehensive Care Plans, the facility failed to include discharge goals in the comprehensive care plan for one of four sampled residents (R) (R104) reviewed for care planning.Findings included:A review of the facility policy titled Comprehensive Care Plans, revised 3/1/2025, indicated that it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The policy continued, 3. The comprehensive care plan will describe, at a minimum, the following: d. The resident's goals for admission, desired outcomes, and preferences for future discharge. e. Discharge plans, as appropriate.A review of the admission Record revealed the facility admitted R104 on 5/26/2023. According to the admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, problems related to unspecified psychosocial circumstances, and functional quadriplegia.A review of the quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 11/20/2025, revealed R104 had a Brief Interview of Mental Status (BIMS) of 15, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff assistance for toileting, showering/bathing, dressing, and personal hygiene.A review of R104's Care Plan Report, for admission date 5/26/2023, lacked evidence of a focus area for the resident's discharge goals.During an interview on 12/29/2025 at 11:50 am, R104 stated they wanted to be in a hospital where they could get surgeries because they wanted to walk again and then have a caseworker to help the resident get to a new place. R104 stated that Social Services Assistant (SSA)6, the resident, and the resident's family member had met and identified three facilities to send referrals, but the resident stated that nobody had accepted the resident. The resident stated they had been accepted by a sister facility, but they did not want to go to that facility. During a follow-up interview on 12/31/2025 at 2:24 pm, R104 stated they wanted to go back to Tennessee.During a phone interview on 1/2/2026 at 10:16 am, the Nurse Practitioner stated she had cared for R104 for over two years, and the resident had been trying to get out of the facility but really had nowhere to go.During an interview on 1/1/2026 at 9:14 am, Social Worker (SW)11 stated she had been employed with the facility since August 2025. She stated R104 felt the facility was trying to keep the resident, and the resident wished to go to Tennessee. SW11 stated that before her employment, the facility had sent multiple referrals to other facilities seeking alternative placement for R104. She stated that as of December 2025, they had begun sending three referrals a month. She stated most of the facilities had declined to admit R104. Per SW11, they were still attempting to get R104 placement in Tennessee.During an interview on 1/1/2026 at 4:07 pm, SSA6 reviewed R104's care plan and stated that the discharge focus area was not on the care plan. She stated that they should have revised R104's care plan once they knew the resident wished to be discharged to another facility closer to family.During an interview on 1/2/2026 at 12:27 pm, the Director of Nursing (DON) stated his expectation regarding discharge was for social services to work (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the resident, make sure everything was in place, and update the care plan.During an interview on 1/2/2026 at 12:22 pm, the Administrator stated her expectation was for resident care plans to be accurate.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and a review of the facility policy titled Enhanced Barrier Precautions, the facility failed to maintain infection prevention and control practices to prevent the transmission and/or development of infection for one of three sampled residents (R) (R15) reviewed for Enhanced Barrier Precautions (EBP). Specifically, staff failed to wear appropriate personal protective equipment (PPE) while providing wound care to R15.Findings included:A review of the facility policy titled Enhanced Barrier Precautions, dated 3/1/2025, revealed that it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Definitions: EBP refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident care activities. The policy also indicated that high-contact resident care activities include wound care: any skin opening requiring a dressing.A review of the admission Record revealed the facility initially admitted R15 on 7/24/2023. According to the admission Record, the resident had a medical history that included diagnoses of pressure ulcer of the sacral region, tracheostomy status, and gastrostomy status.A review of the quarterly Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/27/2025, revealed R15 had severe impairment in cognitive skills for daily decision-making and had a short-term or long-term memory problem per a staff assessment of mental status (SAMS). The MDS indicated R15 required total assistance with all activities of daily living (ADLs). The MDS indicated R15 had one unhealed Stage 3 pressure ulcer/injury. The MDS indicated R15 had a tracheostomy.A review of R15's Care Plan Report included a focus area, initiated 9/29/2024, that indicated the resident was on EBP related to a percutaneous endoscopic gastrostomy tube (PEG tube), tracheostomy, and wounds. Interventions directed staff to utilize PPE per the facility protocol, 9/29/2024.An observation on 12/31/2025 at 2:05 pm revealed that a sign for EBP was posted on R15's room door.An observation on 12/31/2025 at 2:05 pm of wound care provided by LPN7 and LPN8 to R15's left upper buttocks revealed that neither LPN donned a gown before or during wound care. During concurrent interviews immediately after the completion of the wound care, both LPN7 and LPN8 stated they did not don gowns, they should have worn gowns, and it was an oversight.During an interview on 1/1/2026 at 9:21 am, LPN8 stated that gloves, gowns, masks, and goggles, if required, should be worn if a resident is on EBP. LPN8 stated she knew if a resident was on precautions because there would be a sign on the resident's door. LPN8 stated R15 was on EBP because they had a wound and a tracheostomy. LPN8 stated she knew she should have worn a gown during care, but she did not because of nerves.During an interview on 1/1/2026 at 9:33 am, LPN7 stated that gowns and gloves were required for residents on EBP. LPN7 stated she knew if a resident was on EBP because there would be a sign on the resident's door. LPN7 stated R15 was on EBP because they had a wound, tracheostomy, and a PEG tube. LPN7 stated she did not wear a gown during the observed wound care, and she should have worn a gown, but she was nervous.During an interview on 1/1/2026 at 10:39 am, the Director of Nursing (DON) stated that a resident who was on EBP would have a sign on their door to alert staff that the resident was on precautions. The DON stated that hand hygiene, gloves, and gowns were required when providing care to a resident on EBP. The DON stated he expected staff to don the appropriate PPE when caring for a resident on EBP.During an interview on 1/1/2026 at 12:51 pm, the Administrator stated her expectation regarding EBP was that the staff would have followed the proper protocol, and if PPE was required for resident care, the staff should have utilized the proper PPE.