STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265608	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Healthcare	851 Thoroughfare Seymour, MO 65746

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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 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on record review and interview, the facility failed to ensure Minimum Data Sets (MDS - a federally mandated comprehensive assessment instrument completed by facility staff) were accurate when staff failed to address one resident's (Resident #7) ostomy (a surgical opening through the abdomen to form an artificial anal opening) on the resident's MDS. The facility census was 36. Review showed the facility did not provide a policy regarding MDS documentation. 1. Review of Resident #7's face sheet (brief information sheet about the resident) showed the following: -admitted [DATE]; -Diagnoses included colostomy status (surgery to create an opening for the colon (large intestine) through the belly). Review of the resident's physician order sheet (POS), current as of 04/25/24, showed an order, dated 04/17/22, for colostomy care every shift. Review of the resident's quarterly MDS, dated [DATE], showed staff documented ostomy under the bladder and bowel appliance care area. Review of the resident's quarterly MDS, dated [DATE], showed staff documented none of the above under the bladder and bowel appliance care area. Review of the resident's annual MDS, dated [DATE], showed staff documented none of the above under the bladder and bowel appliance care area. Review of the resident's quarterly MDS, dated [DATE], showed staff documented none of the above under the bladder and bowel appliance care area. Review of the resident's care plan, last reviewed on 03/25/24, showed the following: -Resident had a colostomy that he/she will remove at times; -Staff should monitor frequently to ensure colostomy was intact and empty as needed; (continued on next page)

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

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	-Resident will turn on call light at times and ask for his/her colostomy to be emptied; -Staff should monitor frequently. Observation on 04/24/24, at 10:00 A.M., showed the resident resting in bed with an ostomy visible on the right side of abdomen. During an interview on 04/25/24, at 10:40 A.M., the Director of Nursing (DON) said an ostomy appliance should be on the MDS for the resident. The MDS Coordinator was currently unavailable. During an interview on 04/25/24, at 11:00 A.M., Licensed Practical Nurse (LPN) B said that nursing staff notify the MDS coordinator and the DON of care plan and MDS input. Staff should work as a team. Ostomy appliance should be marked on the MDS for the resident. During an interview on 04/25/24, at 11:30 A.M., the Administrator said an ostomy should be on MDS. Any appliance or care area applicable to any resident should be on the MDS. The MDS should be accurate. The MDS Coordinator completed MDS assessments from nurse charting, as well as worked with the residents and interviewed staff. The MDS Coordinator was unavailable.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41787 Based on interview and record review, the facility failed to notify and coordinate with the State-designated authority following newly evident or possible serious mental illness for one resident (Resident #7) who had a temporary approved level two Preadmission Screening and Resident Review (PASARR - a federal requirement to help ensure that individuals who have a mental disorder or intellectual disability are not inappropriately placed in nursing homes for long-term care. The PASARR requires that all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability and be offered the most appropriate integrated setting for their needs (in the community, a nursing facility, or acute care setting) and receive the services they need in those settings). The facility census was 36. Review showed the facility did not provide a policy regarding PASARR requirements. 1. Review of Resident #7's face sheet (a brief information sheet about the resident) showed the following: -admitted [DATE]; -Diagnoses included schizophrenia (disorder that affects a person's ability to think, feel, and behave clearly), intellectual disabilities (limits to a person's ability to learn at an expected level and function in daily life), and anxiety disorder. Review of the resident's Level 1 PASARR, dated 12/15/20, showed the following information: -Does not show any signs of symptoms of major mental disorder; -Had not been diagnosed as having a major mental disorder; -Primary reason for nursing facility placement not due to dementia; -Had a serious problem in levels of functioning in the last six months; -Severe developmental disorder with cognitive delay; -Suspected to have a related condition; -Rule out autism; -Did not qualify for a special admission category. Review of the resident's PASARR evaluation report, dated 12/23/20, showed the following: -The individual's needs could be met in a nursing facility at this time; (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Short term nursing facility level of service with transition to community, consider group home; -Resident had been placed at the nursing facility due to the urgency of his/her condition and living situation. Resident required 24-hour per day supervision due to apparent developmental disability and reported IQ of 50 (moderate range). Resident was unable to make decisions for self, due to intellectual disability. He/she required 24 hours supervision to assure basic needs were met and that he/she was safe. He/she required meal preparation and set up to promote adequate nutrition. He/she required nursing staff to daily evaluate stoma status, to reapply stoma bags several times per day. He/she would benefit from ongoing education regarding the need for stoma bag to remain in place and the benefits of doing so, such as increased activity options. Resident would benefit from nursing facility placement to allow for social interaction to develop friendships; -Guardian had indicated plan to initiate referral for disability services to enable to him/her to live in less restricted level of care in the future, if possible. Nursing facility social services to coordinate the discharge plan with the individual's targeted case manager and regional office community living coordinator to facility the individual's return to the community living situation (with the necessary community supports); -Date processed 12/31/20; -Determination: Yes, resident had Intellectual Disability (ID); -Resident did not need specialty developmental disability services; -The resident did need nursing facility level services; -Recommend for short term nursing facility stay; -Review date 04/30/21; -New DA-124 needed (screening form). Review of resident's Conditional Temporary Approval letter, dated 01/04/21, from Department of Health and Senior Services (DHSS), addressed to the facility administrator, noted the following: -Resident had been referred for a Level II screening for admission into long-term care facility; -After review, the Department of Mental Health (DMH) had determined that the applicant had met the federal definition of Intellectual Disability/Related Condition (ID/RC), but does not require specialized services. Please incorporate the lesser intensity services into the resident's care plan; -Temporarily approved for skilled nursing facility placement from 12/09/20 to 04/30/21 only; -admitted nursing facility must submit new DA-124 forms on 04/15/21. Review of the resident's record showed no additional DA-124 or level 1 forms. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/25/24, at 10:01 A.M., the Business Office Manager (BOM) said he/she had been the previous social worker and the process at that time for DA-124 was that he/she would start the form with the resident identifying information and then give the form to the Director of Nursing (DON) to complete the medical information. The form was then sent in to the states Central Office Medical Review Unit (COMRU). He/she did not know the current process for the DA-124's. During an interview on 04/25/24, at 10:40 A.M., the DON said he/she did not have any knowledge of DA-124 or Level 2. The current social worker was responsible for the process. The social worker was out the facility. During an interview on 04/25/24, at 11:00 A.M., Licensed Practical Nurse (LPN) B said that the social worker was responsible for the PASARR process. During an interview on 04/25/24, at 11:30 A.M., the Administrator said that the DA-124 should be done by the social worker, he/she was also a nurse, and it should be started within 24 to 48 hours. The form was then sent to the Medical Director for signature, if it had not previously been signed by a doctor from the hospital. It was then sent to COMRU. Staff should monitor for return of the level 1 and/or level 2. The Administrator was not at the facility when the resident was admitted . He/she was unsure if the person reading form just did not read that it was only a temporary approval. He/she talked to COMRU on 04/24/24 and the DA-124 would be completed as a new admission.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31464 Based on record review and interview, the facility failed to ensure a PASARR (Preadmission Screening and Resident Review) level one was retained in the resident's medical record and accessible for one resident (Resident #26) of three residents reviewed for PASARR. The facility census was 36. Review showed the facility did not provide a policy regarding PASARR requirements. 1. Review of Resident #26's face sheet (provides basic profile information) showed the following: -admitted [DATE]; -Diagnoses included schizophrenia (mental disorder affecting ability to think, feel, and behave clearly), anxiety disorder, psychotic disorder with delusions (firmly held false beliefs) due to known physiological condition, and encephalopathy (brain disease that alters brain function or structure). Review of the resident's care plan, last updated 04/15/24, showed the following information: -On 09/07/22, staff care planned a history of hollering out and cursing and talking to the voices in his/her head. Resident often speaks of being raped and fighting the demons; -On 01/19/23, staff care planned the resident had experienced trauma and may need assistance to address the physical, behavioral, and or social impacts of the trauma. The resident had developed fear, terror, dread or helplessness following exposure to a traumatic event (sexual assault, war, natural disaster, abuse or violence). Review of a print out of the resident's electronic submission entitled Level One Nursing Facility Pre-Admission Screening for Mental Illness (MI), Intellectual Disability (ID), or Related Condition, dated 12/31/22, showed the following: -Signs or symptoms of a major mental illness: Yes. Resident will yell at evil Spirits who are raping him/her. Psychotic disorder, anxiety disorder, and delusional disorder; -Area of impairment due to serious mental illness: Yes. Serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, and avoidance of interpersonal relationship and social isolation; -Individual has experienced one psychiatric treatment episode that was more intensive than routine follow-up care and/or due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning: Yes (option not designated/unchecked); -Suspected diagnosis or history of Intellectual Disability/Related Condition: Head Injury/Traumatic Brain Injury (TBI); likely to continue indefinitely; (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Results in substantial functional limitation in three or more major life activities: capacity for independent living, self-care,and mobility; -Physician's Authorization and Signature: (left blank); -Diagnoses relevant to Applicant's Functional and/or Skilled Nursing needs: anxiety disorder, psychotic disorder with delusions, psychosis, traumatic subdural (brain injury) with loss of consciousness, hyperglycemia (high blood sugar), osteomyelitis (inflammation or swelling of bone tissue usually the result of an infection), encephalopathy (brain disease), and chronic obstructive pulmonary disease (COPD - breathing disorder); -Behavioral: 6 points = Unstable mental condition monitored by a physician or licensed mental health professional at least monthly or behavior symptoms are currently exhibited OR psychiatric conditions are recently exhibited; -Level of Care Determination by DRL (Division of Regulation and Licensure) Central Office Medical Review Unit (COMRU): Submission incomplete (no determination on level of care by COMRU). Review of the resident's record showed no additional DA-124 (screening form) or Level 1 forms. Review of an email between the facility and Missouri COMRU showed the following: -The Administrator made inquiry on 04/25/24 regarding whether or not there was an approved DA-124 for the resident; -COMRU responded the resident had a Level 2 on record; however, it was more than a year old so a new application would need to be submitted if the facility did not have copies from 2023. During an interview on 04/25/24, at 10:01 A.M., the Business Office Manager (BOM) said he/she had been the previous social worker and the process at that time for DA-124 was that he/she would start the form with the resident identifying information and then give the form to the Director of Nursing (DON) to complete the medical information. The form was then sent into the state's COMRU. He/she did not know the current process for the DA-124's. During an interview on 04/25/24, at 10:40 A.M., the DON said he/she did not have any knowledge of DA-124's or Level 2's. She said the current social worker was responsible for the process. The social worker was out the facility and unavailable for interview. During an interview on 04/25/24, at 11:00 A.M., Licensed Practical Nurse (LPN) B said that the social worker was responsible for the PASARR process. During an interview on 04/25/24, at 1:30 P.M., the Administrator said the social worker was responsible for submitting the DA-124. The facility did not have an available record showing submission, completion, and level of care determination for the resident.

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F 0686 Level of Harm - Minimal harm or potential for 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** 50185 Based on observation, interview, and record review, the facility failed to provide pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) care consistent with professional standards of practice when staff failed to document a complete assessment of a new pressure ulcer and failed to update the care plan timely regarding the skin breakdown and intervention changes for one resident (Resident #20). The facility census was 36. Review of the facility policy, Wound Champion Program, undated, showed the following: -All residents will have a head-to-toe skin assessment completed by the licensed nurse every seven days. The weekly skin assessment should be documented via the electronic medical record's weekly skin assessment. If wounds are identified during the assessment, the nurse must obtain an order for treatment and notify the wound champion; -Always complete weekly skin assessments as scheduled and always report any new skin concerns to the wound champion. Notify the family and the physician of any new wounds, obtain treatment orders, and document accordingly; -When wounds are identified, each wound assessment (location, measurements, odor, exudate, etc.) should be documented in the electronic medical record by wound management. By using this feature, staff can monitor and track healing over time; -Each community is to have a wound champion who will collaborate with the licensed nurses and the Director of Nursing (DON). The wound champion will monitor the progress of each wound weekly and recommend treatment and treatment changes when applicable; -The care plan should reflect the current status of the wound with appropriate goals and approaches. 1. Review of Resident #20's face sheet (document that gives resident information at a glance) showed the following information: -admitted [DATE]; -Diagnoses included malignant neoplasm of rectosigmoid junction (a cancerous tumor of the rectum and colon), chronic kidney disease (a disease of the kidneys leading to kidney failure), type two diabetes, pressure ulcer of sacral (located below the lumbar spine and above the tailbone) region, unspecified stage, and protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in the body's composition and function). Review of the resident's Braden Sale Assessment (tool completed by facility staff to identify patients at risk for pressure ulcers), last revised on 02/07/24, showed the following information: -Resident assessed as mild risk for pressure ulcer development; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Staff did not indicate any interventions and indicated continue current plan of care. Review of the resident's care plan, revised on 02/19/24, showed the following information; -Previous history of skin breakdown to his/her bottom; -Remains at risk for breakdown related to poor nutrition and spending a lot of time in bed/wheelchair; -Ensure he/she has pressure relieving devices to his/her bed and wheelchair; -Monitor skin during activities of daily living cares and baths for signs and symptoms of skin breakdown such as redness, open areas, or blisters; -Assist to the restroom before and after meals, every two hours at night, and as needed. Assist with changing and peri-care after each incontinent episode. Review of the resident's admission Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff), dated 02/26/24, showed the following information: -At risk for developing pressure ulcers; -No unhealed pressure ulcers; -Had pressure reducing devices for bed and chair; -Turning and repositioning program; -Applications of ointments/medications other than to feet. Review of the resident's weekly skin assessment, dated 04/20/24, showed the following information; -Existing non-foot skin issue; -Soft heels; -Resident has pressure reducing devices for bed and chair; -Treatment in place, effective. Review of the resident's progress note, dated 04/20/24, showed redness and open area noted to the resident's bottom with calazime (skin protectant ointment used for temporary relief from skin irritations) applied with rounding. (Staff did not document the exact location of the wound, measurements, an assessment of the wound bed, peri-wound (area around the wound bed), exudate (drainage), pain, or approximation of the wound (how well the edges of the wound are closed). Staff did not document notification of the family, physician, or DON of the wound.) Review of the resident's current Physician Order Sheet (POS), showed the following; (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-An order, dated 04/21/24, for staff to cleanse gluteal fold (horizontal crease that forms below the buttocks, separating the upper thigh from the buttocks)/coccyx (tailbone) with wound cleanser, apply skin prep (wipe that forms barrier between the resident's skin and adhesives to help preserve skin integrity) to peri wound, and cover with calazime (skin protectant with zinc oxide that helps to treat and prevent diaper rash and minor skin irritations) two times a day and as needed. Review of the resident's Wound Management tab, located within the facility's electronic charting system, showed staff did not enter documentation of the resident having a current pressure ulcer. Observation and interview on 04/24/24, 11:07 A.M., showed Certified Nursing Assistant (CNA) D and CNA A entered Resident #20's room to perform incontinence care and get the resident up for lunch. CNA A said there is a current open area to the resident's buttocks. The resident had a superficial, crater-like open area on the resident's coccyx (tailbone) with a beefy red wound bed with additional pencil tip openings observed on both sides of the resident's buttocks, CNA A said the resident has diarrhea a lot and the wound information should be in the chart. Review of the resident's care plan, on 04/25/24, showed staff did not update the care plan with the open area documented in the 04/20/24 weekly progress note. Staff did not document new interventions related to the open area. During an interview on 04/25/24, at 10:57 A.M., Certified Nurse Aide (CNA) A said the resident had an open area on his/her coccyx. The area had been there within this past month. Initially, the resident's skin wasn't this bad, but he/she has problems with his/her bowels, and it has affected his/her skin more this month. Staff would report any new open areas to their charge nurse, the charge nurse would then come and assess the area and give the aides direction from there. During an interview on 04/25/24, at 11:05 A.M., Licensed Practical Nurse (LPN) B said the resident does have an open area that is raw and excoriated. The current treatment is calazime every shift. He/she thought the wound had been there about a week. If an open area was reported to him/her, he/she would go assess the wound and then let the DON know. From there, the two of them would come up with a treatment plan, call the physician and report the wound measurements, assessment of the wound such as if the area is blanchable, bleeding, pain, exudate, and discuss interventions for pressure reduction. The nurse would then document all of that in a progress note, as well as the wound management tab in the electronic medical record. The DON completes the weekly skin assessments. During an interview on 04/25/24, at 9:02 A.M., the DON said the resident has a small shearing open area on his/her bottom that opened at the end of last week. The facility initially does calamine cream treatment. If within a week, the area does not looking better; then, he/she will start measurements, and upgrade treatment. He/she does not have any measurements of the resident's open area documented. The DON said she should probably measure at that moment of an area opening up, but if it's superficial, the facility staff provide treatment of calazime cream for a week then upgrade treatment and measure it at that time. Staff found the open area on the resident's gluteal fold/coccyx, on 04/21/24. He/she likes to see the wounds once a week, and said they get a wound management company on board for pressure related wounds. Assessment of a new open area should be documented in the progress notes. The note should include an initial measurement, and describe the wound with things like; color of the wound bed, exudate, peri wound area, documentation of notification to physician, family, and DON, wound edges, treatment put into place etc. Facility staff do not document the stage of the wound, that is up to the physician or the wound management company. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/25/24, at 11:57 A.M., the Administrator said if staff found an open area on skin, they cannot stage it. They should make the physician aware and get an order to treat. They should document an assessment that includes the size, category, and anything they can describe about it. They also should be measuring/tracking the pressure ulcers weekly. Staff should document in the progress notes and should also make others aware at a weekly resident assessment review meeting. Skin assessments and shower sheets should be looked at during those times as well. The DON completes the weekly wound assessments. The nurses measure the wounds. The physician or wound management company documents the stages of the wounds.

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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** 31464 Based on observation, record review, and interview, the facility failed to provide respiratory care consistent with standards of practice when staff failed to obtain physician orders for and care plan the use of a continuous positive airway pressure (CPAP - a machine that uses mild air pressure to keep breathing airways open while a person sleeps) machine for one resident (Resident #140). Two residents were reviewed for use of oxygen in a facility with a census of 36. Review of a facility policy titled Continuous Pressure Airway Pressure (CPAP) Administration, undated, showed the following: -Purpose to administer continuous positive airway pressure to maintain open airway to the resident with obstructive sleep apnea (breathing repeatedly stops and starts) or respiratory problems breathing when sleeping. -Contact quality assurance (QA) nurse prior to placement for clarification of orders and support; -Check physician's order for pressure setting and method of administration; -CPAP machine should be placed on table near bed; -Fill humidifier with distilled (may use tap) water to appropriate level; -Assist resident as needed with applying and adjusting CPAP mask and head strap. 1. Review of Resident #140's face sheet (give basic profile information) showed the following: -admitted [DATE]; -Diagnoses included chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs) with acute exacerbation, heart failure, shortness of breath, obstructive sleep apnea, and hypoxemia (abnormally low concentration of oxygen in the blood). Review of the resident's nurse's note, dated 04/11/24, showed the following: -Oxygen worn at all times at two liter per nasal cannula; -CPAP at night. Review of the resident's entry tracking Minimum Data Set (MDS - a federally mandated comprehensive assessment tool completed by facility staff), dated 04/11/24, showed no indication of CPAP usage. Review of the resident's physician order sheet (POS), current as of 04/24/24, showed no order for the use of a CPAP machine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265608	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Healthcare	851 Thoroughfare Seymour, MO 65746

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, last updated 04/24/24, showed staff did not document information pertaining to the use of a CPAP machine. Observation on 04/24/24, at 9:20 A.M., showed a CPAP machine on the resident's night stand. During an interview on 04/24/24, at 9:25 A.M., the resident said he/she was supposed to use the CPAP machine at night while sleeping. The resident said sometimes he/she intends to use the machine, but he/she falls asleep before donning the mask and turning on the machine. During an interview on 04/24/24, at 9:45 A.M., Certified Nurse Aide (CNA) A said he/she knew the resident used the CPAP at least sometimes at night. The CNA has turned off the machine in the morning and switched the tubing back over to the oxygen concentrator. During an interview on 04/25/24, at 12:44 P.M., Licensed Practical Nurse (LPN) B said physician orders should be entered per hospital discharge orders or the nurse should call the physician to clarify or get orders. Admission order entry is done by either social services or the admitting nurse. The use of a CPAP machine should have a physician order. The nurse should call to get the physician order if it is not on the hospital discharge orders or in the narrative. LPN B said the resident did have a CPAP, but could not locate an order for its use. The CPAP should also be included on the care plan and information given to the aides during shift report for a new resident or to a new staff person. During an interview on 04/25/24, at 12:52 P.M., the Director of Nursing (DON) said the admitting nurse/staff should get CPAP orders from the physician when they call with admit orders for approval. The DON could not locate an order for the resident's CPAP. The DON said the CPAP use should also be on the care plan. During an interview with the Administrator, DON, and QA Nurse on 04/25/24, at 3:15 P.M., the QA Nurse said a CPAP should have a physician order, be listed on MDS, and be included in the care plan.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50185 Based on observation, interview, and record review, the facility failed to document an assessment of risk versus benefits of side rail use for one resident (Resident #1) and failed to obtain informed consent for the use of side rails prior to installation; failed to address the use of side rails in the care plan; failed to obtain physician orders for the use of side rails; failed to obtain gap measurement for the risk of entrapment; and failed to complete ongoing assessments to ensure the side rails were secure and appropriate for the use of two residents (Resident #1 and #20). The facility census was 36. Review of the facility's policy titled Side Rail/Positioning Bar Protocol, undated, showed the following; -Before placing a Side Rail/Positioning Bar, read the following process to ensure the appropriateness and safety for the resident; -Physician/Director of Nursing/Therapy Department make side rail/positioning bar request to be placed on a specific resident bed. Since the side rail/positioning bar that is typically used for positioning, make sure to ask if the side rail/positioning bar being placed is left, right, or both; -Begin the Side Rail Assessment in the electronic medical record (EMR) and discuss the risks/benefits with the resident (if responsible party) or family/friend (if responsible party) and receive consent. If family/friend is the responsible party, then you may take a verbal consent over the phone, but the verbal must be noted within the additional information section of the observation; -Request for the Maintenance Director to place the side rail/positioning bar on the bed and maintenance will then measure to ensure the safety of the rail. If the measurements pass the safety requirements, the side rail will stay in place. If the side rail/positioning bar do not pass (fail) the safety requirements, then maintenance will remove the side rail. Maintenance Director will not place a side rail/positioning bar without consent being in place. If the measurements fail, then the nurse will need to notify the resident/family that the side rail/positioning bar cannot remain due to the measurements not meeting the safety requirements; -Once the observation is completed, the observation should be printed, and the resident/family will sign the consent line. Please give completed signature form to Medical Records to be uploaded into the resident's EMR; -A final nursing progress note summarizing the side rail observation, measurement, and consent was completed upon placing the left, right, or both side rail/positioning bar; -The side rail/positioning bar should never be placed except by the designee who is measuring for safety requirements. Side rails are never to be placed without measurements and consent. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of Resident # 1's face sheet (a document that gives a patient's information at a quick glance) showed the following; -admitted [DATE]; -Diagnoses included major depressive disorder, malignant neoplasm of esophagus (cancer of the esophagus), type two diabetes, and chronic obstructive pulmonary disease (a lung disease that makes it difficult to breathe). Review of the resident's annual Minimum Data Set (MDS - a federally mandated comprehensive assessment instrument completed by facility staff), dated 02/09/24, showed the following; -The resident had moderate cognitive impairment; -The resident required substantial/maximal assistance from staff to roll left to right in the bed; -The resident required staff to do all of the effort for chair/bed-to chair transfer. Observations on 04/23/24, at 2:42 P.M., and on 04/24/24, at 8:45 A.M., 1:31 P.M., and 1:35 P.M., showed the resident laid in bed with half side rails on both sides of the bed in the upright position. Review of the resident's care plan, revised 02/14/24, showed the following: -Required extensive staff assist with activities of daily living (ADL - activities related to personal care) as he/she is not able to use his/her arms well with abnormality of left elbow; -He/She required two staff assist with Hoyer lift (mechanical lift used to transfer resident) transfers related to weakness and pain; -He/she needed two staff assist with dressing and bed mobility; -He/She needed one staff assist with personal hygiene and bathing. (Staff did not care plan related to the use of side rails.) Review of the resident's April 2024 Physician's Order Sheer (POS) showed staff did not obtained a physician's order for the use of side rails. Review of the resident's medical record showed staff did not document a side rail assessment, gap measurements, or informed consent for the resident's side rails. During an interview on 04/24/24, at 2:09 P.M., Certified Nursing Assistant (CNA) D said the resident had side rails because he/she used the bedside table drawers for positioning assist in the past, which was a risk for the resident. (continued on next page)

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	265608	A. Building B. Wing	04/25/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/24/24, at 2:19 P.M., Licensed Practical Nurse (LPN) B said the resident had side rails because he/she requested them. The nurse did not know of any other reason for the side rails. The nurse looked in the resident's medical record and could not find the side rails addressed in the care plan and could not locate a bed rail assessment/consent for the resident. During an interview on 04/25/24, at 9:02 A.M., the Director of Nursing (DON) said the resident used side rails because the DON requested a u-shaped bar for mobility, however hospice ended up bringing and installing half side rails instead. The facility staff have not completed any follow up on the side rails. Upon review of the care plan, she did not find where staff addressed the use of side rails in the care plan. She could not locate a bed rail assessment/consent, or a physician's order for the side rails in the resident's medical record. He/she had spoken with the resident's family, but did not have any documentation of that. She did not know for sure when hospice installed the side rails. She requested the grab bars (u-shaped bar) because the resident had been reaching over and opening the drawer and grabbing the drawer to pull his/her self over in bed and it was not safe. The DON looked at communication to hospice and said she requested the grab bars on 02/16/24. 2. Review of Resident # 20's face sheet showed the following; -admitted [DATE]; -Diagnoses include malignant neoplasm of rectosigmoid junction (a cancerous tumor involving the rectum and colon), chronic kidney disease (disease of the kidneys leading to kidney failure), type two diabetes, and high blood pressure. Review of the resident's bed rail assessment, dated 02/08/24, showed staff started the assessment and completed the portion of the assessment that addressed the risks/benefits of the side rails. Staff did not document gap measurements of the side rails or informed consent for the side rails. The assessment status showed in progress. Review of the resident's annual MDS, dated [DATE], showed the following; -The resident had severe cognitive impairment; -The resident required substantial/maximal assistance from staff to roll left and right; -Total dependence on staff to move from sitting to lying, and for transfers. Observations showed the following: -On 04/22/24, at 3:23 P.M., the resident laid in the bed with half side rails on both sides of the bed, in an upright position; -On 04/23/24, at 9:38 A.M. and 2:44 P.M., the resident laid in the bed with half side rails on both sides of the bed, in an upright position; -On 04/24/24, at 8:46 A.M., 9:17 A.M., 9:27 A.M., 11:07 A.M., and 1:32 P.M., showed the resident laid in the bed with half side rails on both sides of the bed, in an upright position. (continued on next page)

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	265608	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Healthcare	851 Thoroughfare Seymour, MO 65746

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's care plan, revised 02/21/24, showed the following; -The resident required extensive staff assist of two with ADL cares; -Required two staff assist with dressing and personal hygiene; -Required two-person transfer with the use of a sit to stand lift (a mechanical device with an upper body sling used for lifting the resident to a standing position). (Staff did not address the use of side rails in the care plan.) Review of the resident's April 2024 POS showed staff did not obtain an order for the use of side rails. Review of the resident's medical record showed staff did not document gap measurements for the side rails or informed consent for the resident's side rails. During an interview on 04/24/24, at 2:09 P.M., CNA D said the resident used to be a bad fall risk, sometimes he/she would sit on the edge of the bed. He/she no longer does that, since installing the side rails on the bed. During an interview on 04/24/24, at 2:19 P.M., LPN B said the resident has side rails because he/she requested them, and he/she tends to fall out of bed. During an interview on 04/25/24, at 9:02 A.M., the DON said the resident uses side rails because hospice sent them and set them up. By the time they were on the bed; family requested the side rails to stay in place. She could not find anything side rail related in the care plan. The resident also does not have a physician's order for the side rails. She completed some of the bed rail assessment. She did not include the type of rail, measurements, or consent. He/she has spoken with the resident's family, but does not have any documentation of that. 3. During an interview on 04/24/24, at 1:56 P.M., CNA C said some residents have side rails. To have side rails they must have a physician's order and it is to help the resident with mobility. Residents are not allowed to have full or half side rails without the physician's order. He/She knows if a resident has side rails by looking in the care plan that's found within their charting system on the computer. If side rails are not shown in the care plan, he/she would ask the nurse to update it. If he/she came across a resident he/she thought would benefit from side rails, he/she would address it with the charge nurse and therapy department to see if they could further evaluate the need for them. The charge nurse would then go to the DON to get the physician's order. He/She is unsure if they are supposed to complete an assessment. 4. During an interview on 04/24/24, at 2:09 P.M., CNA D said residents require a physician's order for side rails. If he/she saw a resident that could benefit from side rails, the aide would tell his/her charge nurse. The charge nurse would then tell the DON and they go from there but it's up to the physician at the end of the day. He/She could find out if a resident has side rails by looking in the care plan or the resident's medical record. If he/she could not find the side rail information, he/she would go to the Assistant Director of Nursing (ADON) for direction. (continued on next page)

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	265608	A. Building B. Wing	04/25/2024

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. During an interview on 04/24/24, at 2:19 P.M., LPN B said if a resident required side rails the charge nurse would fill out a bed rail assessment and consent form within the observations tab on the facility computer charting system. This should be completed on admission. He/She would also fill out this assessment any given time, if he/she saw a resident that would benefit, or the resident requested side rails. The assessment includes a measurements section that the Maintenance Director is supposed to complete while placing the side rails. The Maintenance Director makes sure the side rails are safe, then nursing staff inspects them. The assessment also includes the informed consent for the side rails. The assessment is usually filled out on admission, when the need arises, and is reviewed quarterly. When a staff member suggests a resident may benefit, the facility touches base with the physician through their physician book (a book that the physician checks when onsite). The side rails must be for positioning and not for restraint use. The facility would not necessarily need to obtain a physician order, but the facility would confer with the physician. Once a resident has side rails, that information can be found/heard in report, the care plan, and should be documented within the weekly and monthly assessment notes. 6. During interviews on 04/25/24, at 8:51 A.M. and 11:21 A.M., the Maintenance Supervisor said the staff report to him that a resident needs side rails. He obtains the side rails from the shed and installs them. Sometimes the DON will give him a paper form and he will do the measurements on that form. If he doesn't do the measurements, the DON does it. The form he fills out is kept and stored by the DON. He follows up on the side rail installation the next day, as well as obtains weekly measurements. If the measurements differ from the original ones, he will again document on that same form the current measurements. The DON has the original form that he fills out for the side rail measurements. He said that form should include the installation measurements as well has the weekly measurements. When he does the weekly checks, he makes sure the side rails are tight enough, the rails are spaced safely, and any gaps are appropriate. He said he used to do the measurements all the time, but within the last six months, the DON has taken over. Any side rails gap measurements from the last six months would be from the DON. During that time, he has just performed safety checks, such as making sure they aren't loose and work properly. 7. During an interview on 04/25/24, at 9:02 A.M., the DON said gap measurements for side rails are documented under observations in the facility computer charting system. She does not keep a paper record, It's all electronic. The form is called a Bed Rail Assessment and Consent. If a resident needs side rails, it's typically for mobility issues. Facility staff first would complete the Bed Rail Assessment and Consent Form/Contact Family. Staff would let the family and the resident know the risks/benefits for the side rails, obtain consent for the side rails, and then contact the physician for an order. Measurements are requested from maintenance, as he is the one who installs the side rails. Hospice companies may also install bed rails using their equipment company. The maintenance supervisor does the measurements regardless of who installs the side rails. If the maintenance supervisor was not able to complete the measurements, the DON would. Observations, measurements, and consent are all located within the bed rail assessment form. She is unsure if there is follow up or timely reviews after the installation of the side rails. She assumes there would need to be a review if the mattress changed. If remeasurements were needed, there is no additional space on the assessment form to enter those, she would probably document that in a nurses note. Staff is aware of side rail use by looking in the care plan. (continued on next page)

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	265608	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Healthcare	851 Thoroughfare Seymour, MO 65746

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8. During an interview on 04/25/24, at 11:46 A.M., the Administrator said that if a resident needed side rails, the facility would first need to make sure they are going to use it for mobility. They cannot use them as a restraint. Families of the residents often requests side rails to prevent falls, but the facility is aware they cannot do that. She expects staff to get measurements, informed consent, and a physician's order for the side rails. She also expects side rail use to be addressed in the care plan. The maintenance supervisor and/or DON obtain the gap measurements. He/she expects side rails to be reviewed quarterly and as needed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41787 Based on observation and record review, the facility failed to maintain a complete infection prevention and control program when staff failed to ensure Tuberculin Skin Tests (TST) were completed in accordance with the requirements for tuberculosis (TB - a communicable disease that affects the lungs characterized by fever, cough, and difficulty breathing) testing for long-term care employees and per facility policy for three staff members (Director of Nursing (DON), Activity Director (AD), and Laundry E) of ten sampled staff members. The facility census was 36. Review of the facility's policy, titled Tuberculosis Control, undated, showed the following: -All employees will be screened for TB; -Once the decision has been made to employ an individual, the individual will be asked for documentation of a prior Purified Protein Derivative (PPD - a skin test to determine if someone has tuberculosis); -If the employee does not have documentation of a prior PPD, the first step PPD will be administered by the nursing department, documented on the Employee Immunization Record, and must be read prior to or no later than the start date; -If the employee has documented evidence of prior two-step PPD, the decision tree for employee accepts position will be followed; -Documented evidence of prior PPD will be maintained with the facility Employee Immunization Records; -If there is no documentation of prior two-step test, administer first step prior to employment; read results of first step two to three days after administration; -If negative results, administer second step within one to three weeks of employment; -If documentation of first step with negative results within past three weeks prior to employment, administer the second-step within one to three weeks; -Read results of second step test in two to three days after administration; -Negative results, do a one step test by anniversary date of last test and then annually. Review of the general requirements of 19 CSR 20.20.100 (3), TB testing for employees in Long Term Care Facilities, showed the following information: -Long-term care facilities shall screen their employees for TB using the Mantoux method (tool for screening for tuberculosis and for tuberculosis diagnosis) PPD two step tuberculin test within one month prior to starting employment; (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-It is the responsibility of the facility to maintain documentation of each employee's tuberculin status; -If the initial test is negative, the second test should be given as soon as possible within three weeks after employment begins unless documentation is provided indicating a Mantoux PPD test in the past and at least one (1) subsequent annual test within the past two years. 1. Review of the DON's personnel record showed the following information: -Hire/start date of 09/06/22; -An annual TB test from another facility, dated 08/10/22, showed a result of negative; -The facility did not have documentation of a second step test administered/read or documentation indicating a Mantoux PPD test in the past and at least one subsequent annual test within the past two years 2. Review of the AD's personnel record showed the following information: -Hire/start dated of 02/06/23; -The facility did not have documentation of a step 1 or step 2 TB test administered. During an interview on 04/25/24, at 10:01 A.M., the Business Office Manager (BOM) said staff administered an annual TB test on the AD on 04/24/24, but was unable to locate any testing from his/her previous employer. 3. Review of Laundry E's personnel record showed the following information: -Hire/start date of 10/12/23; -The facility did not have documentation of step 1 or step 2 TB test administered. During an interview on 04/25/24, at 10:01 A.M., the BOM said there was not a test result located for Laundry E. 4. During an interview on 04/25/24, at 10:01 A.M., the BOM said when an employee is hired, any nurse can administer and read the TB testing required. The social worker is also the infection control nurse and she tracks the staff TB testing. The social worker was out of the office. 5. During an interview on 04/25/24, at 10:40 A.M., the DON said once an employee had been interviewed and hired, a TB skin test was administered. The TB test is read 48 to 72 hours after administered. The new staff is then told to report to a nurse in 10 days to receive the second step TB test. The social worker also tracked staff TB testing. 6. During an interview on 04/25/24, at 11:30 A.M., the Administrator said the TB test is done on hire and read on the day of orientation. The second step completed within a couple weeks. This should always be done with all new employees.