

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Glenwood Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 550 Glenwood Drive Mooresville, NC 28115	
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 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** Based on record review and staff interviews, the facility failed to ensure a Preadmission Screening Resident Review (PASRR) was completed for a resident with a diagnosis of a serious mental illness for 2 of 3 residents reviewed for PASRR (Resident #80 and Resident #87). The findings included: a. A review of the medical record revealed a Level I PASRR was completed for Resident #80 on 11/05/19 but did not include his active diagnoses of mental illness. The Level I PASRR determination letter noted Resident #80 did not to meet the federal definition for mental illness and was assigned a PASRR number with no expiration. Resident #80 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, anxiety disorder, and delusional disorder. A review of the medical record revealed no evidence a Level II PASRR evaluation was completed for Resident #80. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #80 was cognitively intact, exhibited no behaviors or rejections of care, had active diagnoses including depression, anxiety disorder and psychotic disorder (other than schizophrenia), and she was receiving anti-anxiety and anti-depressant medications. The MDS indicated Resident #80 was not currently considered by the state Level II PASRR authority to have a serious mental illness or intellectual disability. b. A review of the medical record revealed a Level I PASRR was completed for Resident #87 on 3/23/23 but did not include her active diagnoses of mental illness. The Level I PASRR determination letter noted Resident #87 did not to meet the federal definition for mental illness and was assigned a PASRR number with no expiration. Resident #87 was admitted to the facility on [DATE] with diagnoses that included post-traumatic stress disorder (PTSD). A review of the medical record revealed no evidence that a Level II PASRR evaluation was completed for Resident #87. The admission MDS dated [DATE] indicated Resident #87 was cognitively intact, exhibited no behaviors or rejections of care, had an active diagnosis of PTSD and he was receiving anti-anxiety and anti-depressant medications. The MDS indicated Resident #87 was not currently considered by the state Level II PASRR authority to have a serious mental illness or intellectual disability. An interview was conducted with the Director of Social Services on 7/10/26 at 9:34 AM revealed she assumed the role of Director of Social Services in January 2026 and was responsible for ensuring a Level I PASRR was completed for residents prior to admission to the facility. She indicated the hospital case managers usually completed the Level I PASRR prior to admission however she reviewed the Level I screen in the North Carolina Medicaid Uniform Screening Tool (NC MUST-an internet-based application utilized to communicate and manage PASRR requests) to ensure it was completed during the most recent hospitalization and included any diagnoses of mental illness. She stated when Resident #80 and Resident #87 were admitted to the facility the Former Director of Social Services was responsible for this and should have completed new Level I PASRR screens for Resident #80 and Resident #87 to include their diagnoses of mental illness and submitted them for review. Attempts made to contact (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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Former Director of Social Services on 7/09/26 at 12:53 PM and 7/10/26 at 10:09 AM were unsuccessful. An interview conducted with the Administrator on 7/10/26 at 11:30 AM indicated the Director of Social Services was responsible for ensuring a Level I PASRR was completed for all residents prior to admission and reviewing the Level I PASRR screens completed by the hospital to ensure it was submitted for review during the most recent hospitalization and included the resident's diagnoses of mental illness. The Administrator stated the Former Director of Social Services should have completed new Level I PASRR screens for both Resident #80 and Resident #87 and submitted them for review.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff interviews, the facility failed to maintain a medication error rate of less than 5%, as evidenced by the administration of medications that were ordered and manufactured to be administered whole after they were crushed prior to administration. This resulted in 2 medication errors out of 25 medication administration opportunities, for a medication error rate of 8% for 1 of 3 residents (Resident #77) observed during the medication pass. The findings included: Resident #77 was admitted to the facility on [DATE] with diagnoses that included heart failure. Review of the Physician's Orders in Resident #77's electronic medical record revealed an active physician order dated 11/30/25 for Potassium Chloride Crystals Extended-Release Oral Tablet 20 mEq, administer one tablet by mouth once daily for low potassium. The order further instructed, Do not chew or crush. Review of the Physician's Orders in Resident #77's electronic medical record revealed an active physician order dated 06/17/26 for Metoprolol Succinate Extended-Release oral tablet release 24-hour 25 milligram (mg) administer one tablet by mouth daily for hypertension. On 07/07/26 at 8:45 AM an observation and interview were conducted with Nurse #1. Nurse #1 was observed preparing medications for Resident #77. Nurse #1 removed one tablet labeled Potassium Chloride Crystals Extended-Release Oral Tablet 20 mEq and one tablet labeled Metoprolol Succinate Extended-Release 25 mg. The surveyor asked Nurse #1 how Resident #77 took her medications. Nurse #1 stated she planned to place the potassium tablet in a separate medication cup and crush the remaining medications. Nurse #1 was then observed placing both the Potassium Chloride Extended-Release tablet and the Metoprolol Extended-Release tablet into the same medication cup and crushing both medications. Nurse #1 proceeded to Resident #77's bedside, asked the resident to state her name, and after Resident #77 stated her first name, administered the crushed medications. An interview with Nurse #1 on 07/07/26 at 10:05 AM revealed she was unaware the physician's order for Potassium Chloride instructed that the medication should not be chewed or crushed. Nurse #1 further stated she did not realize the Metoprolol 25 mg was an extended-release medication and should not be crushed. She explained she had previously received education regarding medications that should not be crushed but became nervous while being observed by the surveyor and made a mistake. An interview with the Director of Nursing (DON) on 07/09/26 at 11:22 AM revealed Nurse #1 should have compared the medication package to the physician's orders, reviewed the physician's instructions not to crush the Potassium Chloride, and recognized that extended-release medications should not be crushed.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and staff, Pharmacist, and Medical Director interviews, the facility failed to ensure a resident was free of significant medication errors when extended-release medications that were ordered to be administered whole were crushed prior to administration for 1 of 3 residents (Resident #77) observed during the medication pass. Findings included: Resident #77 was admitted to the facility on [DATE] with diagnoses that included heart failure. Review of the physician's orders in Resident #77's electronic medical record revealed an active physician order dated 11/30/25 for Potassium Chloride Crystals Extended-Release Oral Tablet 20 milliequivalents (mEq), administer one tablet by mouth once daily for low potassium. The order further instructed, Do not chew or crush. Review of the physician's orders also revealed an active physician order dated 06/17/26 for Metoprolol Succinate Extended-Release 24-hour oral tablet 25 milligrams (mg), administer one tablet by mouth once daily for hypertension. On 07/07/26 at 8:45 AM, an observation and interview were conducted with Nurse #1 during the medication pass for Resident #77. Nurse #1 was observed preparing the resident's scheduled medications. Nurse #1 removed one Potassium Chloride Crystals Extended-Release Oral Tablet 20 mEq and one Metoprolol Succinate Extended-Release 25 mg tablet. The surveyor asked Nurse #1 how Resident #77 normally took her medications. Nurse #1 stated she planned to place the Potassium Chloride tablet into a separate medication cup and crush the remaining medications. Nurse #1 was then observed placing both the Potassium Chloride Extended-Release tablet and the Metoprolol Succinate Extended-Release tablet into the same medication cup and crushing both medications. Nurse #1 proceeded to Resident #77's bedside, asked the resident to state her name, and after Resident #77 stated her first name, administered the crushed medications. On 07/07/26 at 10:05 AM, an interview was conducted with Nurse #1. Nurse #1 stated she was unaware the physician's order for Potassium Chloride instructed the medication should not be chewed or crushed. Nurse #1 further stated she did not realize the Metoprolol 25 mg was an extended-release medication and should not be crushed. Nurse #1 explained she had previously received education regarding medications that should not be crushed but became nervous while being observed during the medication pass and made a mistake. On 07/08/26 at 8:18 AM an interview was conducted with the facility Pharmacist. The Pharmacist stated Resident #77 had active physician orders for Metoprolol Succinate Extended-Release 25 mg and Potassium Chloride Crystals Extended-Release 20 mEq. The Pharmacist explained extended-release medications should never be crushed because crushing destroys the extended-release delivery system, resulting in the medication being released immediately rather than gradually over the intended dosing interval. The Pharmacist stated crushing these medications altered their intended release characteristics and could affect medication absorption and therapeutic effectiveness. On 07/09/26 at 11:22 AM, an interview was conducted with the Director of Nursing (DON). The DON stated Nurse #1 should have compared the medication packaging with the physician's orders, followed the physician's instruction not to crush the Potassium Chloride tablet, and recognized that Metoprolol Succinate Extended-Release should not be crushed. The DON stated medications should be administered according to the physician's orders and manufacturer recommendations. On 07/09/26 at 1:29 PM, an interview was conducted with the Medical Director. The Medical Director stated crushing extended-release medications was not appropriate because doing so altered the intended release characteristics of the medications and could increase gastric irritation. The Medical Director stated he did not believe Resident #77 experienced actual harm because the facility was monitoring the resident's potassium level and blood pressure; however, crushing the medications was not the appropriate method of administration.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, Nurse Practitioner (NP), Speech Language Pathologist (SLP) and staff interviews, the facility failed to implement an effective system to ensure that a severely cognitively impaired resident with a diagnosis of dysphagia received the correct food texture (mechanical soft) as ordered by the physician (Resident #32). On 7/6/26, Resident #32 was observed in her bed sitting upright with her lunch tray in front of her on her overbed table. The lunch plate revealed a whole, soft dinner roll, ground turkey chili with beans over cream of rice, and whole asparagus spears. Resident #32 was observed trying to pick up the asparagus spears with her right hand and attempted to chew one spear but was unsuccessful in eating any of the asparagus. On 7/7/26 during the breakfast meal, an observation revealed Resident #32 in bed, sitting upright with her breakfast tray in front of her on her overbed table. The tray revealed one large slice of thick cut bacon and a whole, un-mashed hard-boiled egg. The whole hard-boiled egg was observed to have a small area with teeth indentation. This deficient practice occurred for 1 of 1 resident reviewed for correct diet textures (Resident #32). The findings included: A review of Resident #32's hospital speech therapy dysphagia treatment note dated 5/27/26 revealed she was seen for suspicion for oropharyngeal dysphagia (difficulty moving food and liquids from your mouth into your throat and esophagus). The note indicated Resident #32 was edentulous (lacking any natural teeth) and her dentures were not available. The note further indicated Resident #32's behaviors were consistent with that of cognitive related dysphagia associated with advanced cognitive decline. The SLP noted Resident #32 exhibited oral holding (keeping food, liquid, or saliva in the mouth, cheeks, or floor of the mouth instead of swallowing it) with prolonged anterior to posterior transit (longer than normal for food or liquid to move from the front of the mouth to the back of the tongue during the oral phase of a swallow) when given a meal trial of puree (a smooth, pudding-like consistency requiring no chewing) solids and thin liquids. The note revealed there were no overt clinical signs and symptoms of aspiration (accidentally breathing food or liquid down the windpipe and into the lungs instead of the esophagus) and no globus sensation (a feeling of lump, tightness, or something stuck in the throat when no physical blockage was present). The SLP recommended an eating technique of slow rate, small bites and sips of liquids and monitoring for fatigue intermittent and periodic monitoring for supervision and medication to be given one at a time and as tolerated. A review of Resident #32's hospital Discharge summary dated [DATE] indicated she had a physician's order for pureed texture diet. Resident #32 was admitted to the facility on [DATE] with diagnoses which included oropharyngeal phase dysphagia, moderate protein-calorie malnutrition, cirrhosis of the liver, and a non-ruptured cerebral aneurysm. A review of Resident #32's physician's orders revealed an order for a regular diet, puree texture with thin liquids consistency for dysphagia dated 5/29/26. Resident #32's admission Minimum Data Set (MDS) dated [DATE], revealed she was severely cognitively impaired. She required setup assistance when eating. The MDS indicated Resident #32 had a swallowing disorder and was on a mechanically altered diet. The MDS further revealed Resident #32 complained of difficulty or pain with swallowing. The MDS indicated Resident #32 had no concerns with oral or dental status, and she was not edentulous (completely lacking or missing all natural teeth). The MDS also indicated Resident #32 was not coded for broken or loosely fitting full or partial dentures (the section was left blank). A review of a speech therapy treatment encounter note dated 6/4/26 and written by the SLP revealed Resident #32 was seen for skilled speech therapy for addressing swallowing function. The SLP presented Resident #32 (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/6/26 to mechanical soft. She indicated she was not aware the asparagus spears should have been cut or chopped up for a mechanical soft texture. The Dietary Manager stated Resident #32's breakfast meal tray on 7/7/26 was incorrect and the bacon should not have been on the tray, a ground turkey sausage link was supposed to be on the tray. The Dietary Manager stated the hard-boiled egg should have been mashed up by kitchen staff or by NA #1. A follow-up interview with the Dietary Manager and the Regional Director of Operations for Dining Services occurred on 7/27/26 at 10:39 AM. The Dietary Manager stated Resident #32's meal ticket on 7/6/26 had the letter G on it, a diet texture not offered at the facility. The Dietary Manager stated she entered the diets into the meal ticket system but did not know how the letter G was on the ticket for Resident #32. She assumed it was put into the system by error as a typo and the computer system generated a diet not offered at the facility. The Dietary Manager stated the G was most likely added by mistake and she did not know by who. She stated the meals on 7/6/26 and 7/7/26 were set up by the cook in the kitchen who scooped out the food onto the plate while a Dietary Aide called out the meal and diet texture on the ticket. An additional Dietary Aide would take the plate and place it on the serving cart to be delivered to residents' rooms. The Dietary Manager stated on 7/6/26, Resident #32's lunch meal should have had a mechanical soft texture, and she was not aware cooked asparagus should have been chopped or ground up to be compatible with a mechanical soft texture. She explained all residents on a mechanical soft texture diet in the facility did not receive chopped or ground asparagus during the lunch meal on 7/6/26. The Dietary Manger stated Resident #32's meal ticket indicting pureed bread was missed due to the Dietary Aides reading the top of the ticket that indicated a mechanical soft texture and most likely, the puree note next to the bread was ignored. She explained on a mechanical soft diet texture, Resident #32 was able to have a regular, soft dinner roll and a pureed texture was not needed. The Dietary Manager stated Resident #32 most likely received one slice of thick cut bacon for the breakfast meal on 7/7/26 as the slices were a larger size. She stated bacon cannot be made into a mechanical soft texture, so ground turkey sausage should have been on Resident' #32's plate for her breakfast. The Dietary Manager explained other residents on a mechanical soft diet texture received ground turkey sausage the morning of 7/7/26. She stated the bacon served was actually turkey bacon and she assumed one of the Dietary Aides made a mistake by placing the turkey bacon on the plate instead of the ground turkey sausage. The Dietary Manager indicated she was not aware that a hard-boiled egg needed to be mashed up or ground before it left the kitchen to be compatible with a mechanical soft texture diet. She explained all residents who received a mechanical soft diet for the breakfast meal on 7/7/26 were served a whole hard-boiled egg, not mashed up. A review of the Dietary Staff schedule revealed Dietary Aide #1 worked 7/6/26 and 7/7/26 from 7:00 AM until 2:30 PM. Dietary Aide #2 worked on 7/6/26 from 7:00 AM until 2:30 PM. A combined interview with Dietary Aide #1 and Dietary Aide #2 occurred on 7/27/26 at 12:44 PM. Dietary Aide #1 stated Resident #32's lunch meal on 7/6/26 and breakfast meal on 7/7/26 were incorrect and the kitchen staff made a mistake by not giving Resident #32 the correct texture diet and food selections indicated on the ticket. Dietary Aide #1 and Dietary Aide #2 explained when trays were prepared in the kitchen, one of the Dietary Aides would call out the information on the ticket, the [NAME] scooped the food onto the plate, then the next Dietary Aide would check the plate before the tray went on the meal cart. An interview with the SLP on 7/9/26 at 10:28 AM revealed Resident #32 was admitted to the facility originally with a pureed diet and was upgraded on 6/5/26 to a mechanical soft texture diet. She stated Resident #32 was able to safely eat breads and they did not need to be pureed. The SLP stated asparagus spears were not typically considered a soft vegetable and should have been ground up before being served to Resident #32. She stated the hard-boiled egg should have (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Glenwood Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 550 Glenwood Drive Mooresville, NC 28115	
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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been mashed up by the NA if not by kitchen staff. The SLP also stated bacon was not on a mechanical soft diet, but the turkey sausage could be ground up or sliced to the appropriate texture. She indicated Resident #32 finished her recent speech therapy on 6/24/26 and was not upgraded to a regular texture diet and still had minimal dysphagia. An interview with Unit Manager #1 on 7/8/26 at 3:29 PM revealed Resident #32 needed set up assistance from staff. She stated NAs were expected to pass out the meal trays to all residents and they were to check the meal tickets on the tray to ensure each resident received the correct meal and diet. Unit Manager #1 stated if the NAs noticed any mistakes with the food texture or food selections on the tray not matching the ticket on the tray, she would expect them to go back to the kitchen and get the correct meal. She was unsure why NA #1 did not notice the meal trays at both lunch on 7/6/26 and breakfast on 7/7/26 were the incorrect diet texture. An interview with the NP occurred on 7/27/26 at 1:21 PM. She stated she had the expectation that facility staff should serve the correct diet and texture to Resident #32 and all other residents. She indicated nursing staff, including NAs were trained to double-check tickets and meals for the correct diets and textures. The NP stated that ultimately, the meal tray for Resident #32 should have had the correct mechanical soft diet texture for her to eat. A telephone interview with the Director of Nursing (DON) on 7/10/26 at 10:49 AM was conducted. She had the expectation NA #1 and all other NAs to understand different diets and textures and to review the meal tickets to make sure the meal trays had the correct diet and texture before giving them to Resident #32 and all other residents. A follow-up interview with the DON on 7/27/26 at 2:16 PM revealed training for new NAs upon hire was three days on the job training after orientation with another trained NA, but more training was available if the NA requested it. The DON stated she expected the incorrect diet texture during the lunch meal served to Resident #32 on 7/6/26 and incorrect diet texture during the breakfast meal on 7/7/26 to have been caught by NA #1. The DON stated NA #1 was trained to review meal tickets for accuracy before serving them to residents. A telephone interview was conducted with the Administrator on 7/10/26 at 10:57 AM. He stated had the expectation Resident #32 should have been served the correct diet and consistency by staff.		