

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 366095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/22/2025
NAME OF PROVIDER OR SUPPLIER Glenwood Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 836 West 34th Street NW Canton, OH 44709	

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on observation, medical record review, review of witness statements, review of mechanical lift manual, interview, and review of facility plan of correction documentation, the facility failed to ensure mechanical lift equipment was maintained in a safe and working condition to prevent an avoidable fall for Resident #23. This affected one (Resident #23) of three residents reviewed for falls. The facility census was 64. Findings include: Review of the medical record for Resident #23 revealed an admission date of 04/25/16 with diagnoses which included schizoaffective disorder bipolar type, metabolic encephalopathy, obesity, pseudobulbar affect, altered mental status, generalized anxiety disorder, major depressive disorder, and chronic pain syndrome. Review of the activities of daily living (ADL) care plan revised on 02/02/21 revealed Resident #23 had an ADL self-care performance deficit related to anxiety, behaviors, congestive heart failure, generalized weakness, history of falls, impaired vision, obesity, pain, poor balance, psychoactive drug use and hypothyroidism with interventions including that the resident was dependent on chair-to-bed or bed-to-chair transfers and mechanical lift for transfers with two-person assistance. Review of the Minimum Data Set (MDS) 3.0 quarterly assessment dated [DATE] revealed Resident #23 was cognitively intact, used a wheelchair for mobility, was totally dependent on staff for toileting, bathing, personal hygiene, and transferring. Review of the late entry nurse note dated 12/05/25 timed 11:50 A.M. created on 12/06/25 timed 2:50 A.M. authored by Registered Nurse (RN) #72 revealed the aide informed the nurse that during the process of hoisting a resident, the Hoyer (mechanical lift) pad broke, and the resident fell on his buttocks. They grabbed another Hoyer pad and continued. The hydraulics failed with the Hoyer machine; this time, the resident fell and sustained a small injury on the forehead, close to the bridge of the nose, and on the left hand. The resident said the Hoyer pad broke, and he fell. The second time, he was unable to explain what happened, but he said I fell down from the Hoyer again, claimed he hit his forehead, right knee and left hand hurt. Vital signs checked immediately: 139/101 blood pressure, 90 pulse, 20 respirations and 97.8 temperature. Range of motion completed. The resident complained of pain in the right knee and forehead. Physical assessment from head to toe. The was an injury on the left hand, particularly at the back of the hand, and one close to the bridge of the nose. Had his scheduled pain medications before the incident. The wound was cleaned and dressed. Said he did not want any other pain medications because he was sure the hospital will give him pain medication again. Physician aware and ordered to send him to the emergency room (ER). He was taken to the emergency room. Review of the hospital discharge documentation dated 12/06/25 timed 12:51 A.M. revealed Resident #23 was diagnosed with a fall and had no post-acute orders. Additional information revealed to follow-up with the doctor, keep wound clean and dry, return if worsening or concerning symptoms. Review of the nurse note dated 12/06/25 timed 5:47 A.M. revealed Resident #23 was brought back from the ER with no other new orders. Vitals were checked and recorded and neurological checks continued. Review of the eMAR Medication Administration Note dated 12/06/25 timed 9:08 A.M. revealed Resident #23 was administered Acetaminophen oral tablet 500 milligrams (mg) with instructions to give 1000 milligrams (mg) every eight hours as needed for mild pain related to chronic pain syndrome. Resident complained of generalized pain and left knee pain; 10 out of 10 on the pain scale. Review of the eMAR Medication Administration Note dated 12/06/25 timed 9:10 A.M. revealed Resident #23 was administered Cyclobenzaprine HCl (a muscle relaxant medication) oral tablet with instructions to give 10 mg orally every eight hours as needed for muscle spasms. Resident #23 complained of generalized pain and left knee pain; 10 out of 10 on the pain scale. Review of the nurse note dated 12/06/25 timed 7:00 P.M. revealed Resident #23's representative returned the call for notification of the resident's fall on 12/05/25. No concerns were voiced at this time. Review of the fall care plan revised on 12/06/25 revealed Resident #23 was at risk for falls related to behaviors: hoarding items in room, history of falls, medications, obesity, poor balances, psychoactive drug use with interventions which included: implement preventative fall interventions/devices and inspect Hoyer pad prior to use/transfer. Review of Resident #23's witness statement obtained via telephone by the Administrator dated 12/06/25 revealed Resident #23 was picked up from his chair to be put in bed and the strap broke. The resident's back hit the side of the bed and then buttock on the floor. The second time Resident #23 was lifted, the resident thought the strap broke again. Resident #23 did not see the staff switch the lift but the staff did nothing different than</p>		