STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515028	A. Building B. Wing	02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Healthcare Center	1924 Glen Wood Park Road Princeton, WV 24739

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 39043 Based on observation, record review, and staff interview, the facility failed to ensure a safe, clean, comfortable, home-like environment. Packaged terminal air conditioner (PTAC) units contained dirt and debris. These were random opportunities for discovery. Resident identifiers: #1, #57, #23. Facility census: 80. Findings included: a) PTAC units On 02/10/25 at 11:44 PM, the packaged terminal air conditioner (PTAC) unit in Resident #57's room was observed to have debris, including an adhesive bandage, in it. On 02/10/25 at 12:04 PM, the PTAC unit in Resident #23's room was observed to have debris in it. On 02/10/25 at 12:07 PM, the PTAC unit in Resident #1's room was observed to have dirt in it. On 02/11/25 at 10:35 AM, the Housekeeping Manager and Regional Manager confirmed the dirt and debris in the PTAC units for Residents #57, #23, and #1. They stated PTAC units are cleaned by the Maintenance Department. On 02/11/25 at 10:50 AM, the Maintenance Director stated the PTAC units are cleaned every three (3) months. He confirmed the dirt and debris in the PTAC units for Residents #57, #23, and #1 and stated the units would be cleaned. The Maintenance Director was asked when these units were last cleaned. He provided paperwork documenting the units had been cleaned on 12/10/24.

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	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 51553 Based on record review and staff Interview, the facility failed to revise the care plan for Resident #49 in the area of weight management. Resident identifier: #49. Facility census: 80. Findings included: a) Resident #49 Multiple care areas in the care plan had interventions that included weight management and monitoring 02/12/25 9:20 PM, the Director of Nursing (DON) confirmed Resident #49 had an order for no weights in February. The DON confirmed there was no documented weight for January and there were multiple areas in the care plan for weights to be obtained and monitored. The DON stated, Just about every care plan. The DON reported the patient had multiple refusals for weights to be obtained and had requested no weights.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 49751 Based on observations and staff interview, the facility failed to appropriately dispose of a soiled brief for #46. This was a random opportunity for discovery during the Long - Term Care Survey process. Facility Census: 80 Resident identifier: #46 Findings included: a) Resident #46 02/10/25 11:32 AM the surveyor observed Resident #46 being provided ADL care by Nurse Aide (NA) #75 behind the curtain. The surveyor waited outside the doorway and noticed a soiled brief was placed on the fall mat on the left side of the bed by NA #75. The fall mat was lying on the floor. 02/10/25 11:36 AM Unit manager Registered Nurse (RN) # 71 was coming down the hall by the surveyor. The surveyor asked about the brief and now soiled linens that were observed placed on the fall mat by NA# 75. RN# 71 went into the room and saw the soiled brief and soiled wash cloths were on the fall mat. RN #71 came back to the door to this surveyor and stated They(NA's) should not be placing any soiled items on the bare floor. 02/10/25 11:41 AM this surveyor observed NA #75 place soiled items in a trash bag and clean floor mat.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 51553 Based on Record Review, Staff Interview and Observation, the facility failed to provide posey palm protectors bilaterally as ordered for Resident #30 to prevent further avoidable reduction of range of motion (ROM). Resident identifier: #30. Facility census: 80. Findings included: a) Resident #30 Medical record review revealed bilateral palm posey/protectors were ordered for Resident #30. Two (2) observations for no right palm protector for Resident #30 were completed on 02/10/25 and 02/11/25. On 02/11/25 10:45 AM, no right palm protector was observed on Resident #30. On 02/11/25 10:45 AM, Licensed Practical Nurse (LPN) #39 confirmed no palm protector on the right hand for Resident #30. LPN #39 stated, I'm not sure about it. I will have to find it. LPN reported later that staff found the palm protector in laundry and an order for the resident to wear the palm protectors for 6-8 hours was confirmed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 39043 Based on observation, record review and staff interview, the facility failed to provide appropriate care and services regarding indwelling catheter care. This was a random opportunity for discovery. Resident identifier: #23. Facility census: 80. Findings included: a) Resident #23 The facility's policy titled Catheter Care, with approval date 03/01/24, gave instructions to check that collection bag is not on the floor and is draining properly and secured allowing for no reflux of urine back to the bladder. On 02/10/25 at 11:56 AM, Resident #23 was observed lying in bed with his bed in the lowest position. The resident's indwelling catheter urine collection bag was lying on the floor. There was a plastic basin under the resident's bed, but the indwelling catheter urine collection bag was not in the basin. The indwelling catheter urine collection bag was identified on the bag as a Sterigear Fig Leaf lite brand. This brand had a cover attached to the front of the bag to protect the resident's dignity by preventing the urine in the bag from being viewed by others. During a second observation on 02/10/25 at 4:10 PM, Resident #23's indwelling catheter urine collection bag continued to be lying on the floor. This was confirmed by Registered Nurse (RN) #3. During an interview on 02/11/25 at 2:29 PM, the Administrator stated she believed the dignity cover attached to the front of the urine collection bag was folded under the collection bag, which prevented the collection bag from lying on the floor. The Administrator was informed that the dignity cover was not folded under the collection bag when observed by the surveyors. The Administrator confirmed the facility's policy did not give instructions to fold the dignity cover under the collection bag. Review of the Fig Leaf lite collection bag product fact sheet provided by the facility stated the built-in, attached cover was to hide fluid from view to restore patient dignity and improve the environment for caregivers and visitors. The product fact sheet gave no information regarding use of the attached cover as an infection control measure. During an interview on 02/12/25 at 2:19 PM, the Infection Preventionist (IP) stated plastic basins are kept under urine collection bags in case the bags fall off the bed.

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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. 39043 Based on observation, record review, and staff interview, the facility failed to ensure oxygen therapy services were administered in accordance with professional standards of treatment. Resident #42 and Resident #73's oxygen flow rates were not set at the physician prescribed rates. In addition, Resident #42's oxygen concentrator was not functioning properly. These were random opportunities for discovery. Resident I=identifiers: #42 and #73. Facility census: 80. Findings included: a) Resident #42 On 02/10/25 at 12:12 PM, Resident #42 was observed to be wearing oxygen by nasal cannula at a flow rate of 1.5 liters per minute (LPM). Review of Resident #42's physician's orders showed an order written on 05/25/23 for Oxygen 2 LPM via nasal cannula continuously every shift for shortness of breath. On 02/11/25 at 9:00 AM, Resident #42 was again observed to be wearing oxygen by nasal cannula at a flow rate of 1.5 LPM. On 02/11/25 at 10:45 AM, Registered Nurse (RN) #47 confirmed Resident #42's oxygen was set to 1.5 LPM and should have been set to 2 LPM. RN #47 attempted to increase the resident's oxygen to 2 LPM but the oxygen concentrator was not working properly and would not stay at 2 LPM. RN #47 stated she would obtain a new oxygen concentrator for the resident. b) Resident #73 On 02/10/25 at 11:19 AM, Resident #73 was observed to be wearing oxygen by nasal cannula at a flow rate of 2 liters per minute (LPM). Review of Resident #73's physician's orders showed an order written on 10/15/24 for O2 [oxygen] at 4L via NC [nasal cannula] continuous for SOB [shortness of breath] or s/s [signs and symptoms] of hypoxia. On 02/11/25 at 9:16 AM, Resident #73 was again observed to be wearing oxygen by nasal cannula at a flow rate of 2 LPM. On 02/11/25 at 10:27 AM, Registered Nurse (RN) #47 confirmed Resident #73's oxygen was set to 2 LPM and should have been set to 4 LPM.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49751 Based on record review and staff interviews, the facility failed to ensure medical records were maintained accurately for two (2) of 27 residents. The facility did not obtain clarification for duplicate orders for bilateral posy palm protectors for Resident #30. Resident #12 had an incorrect order regarding PO (by mouth) medications. Resident identifiers: #12 and #30. Facility census: 80. Findings include: a) Resident #12 During record review on 01/11/25 at approximately 10:00 AM Resident has an order stating NPO(nothing by mouth). Further record review revealed an order placed on 02/08/25 for Amoxicillin-Pot Clavulanate Tablet 875-125 MG Give one (1) tablet by mouth two times a day for bacterial infection for five (5) days Pneumonia -start date-02/08/2025 2100 Further record review of the Medication Administration Record (MAR) revealed the medication was given on 02/08/25 PM and on 02/09/25 AM and PM and on 02/10/25 AM. Review of the MAR gave the indication that the medication was given by mouth. During an interview, on 02/11/25 at 10:30 AM with Registered Nurse (RN) # 71, the RN stated the order was not reviewed by clinical team and assured the medication was not given by mouth. 02/11/25 10:40 AM during an interview with Registered Nurse (RN) #3 the RN stated she gave the medicine crushed via peg tube. The RN said, She takes nothing by mouth, I give all meds via peg tube. 51553 b) Resident #30 On 02/10/25 3:50 PM, a palm protector for the left hand was observed on Resident #30. No palm protector for the right hand was observed. Bilateral palm posey/protectors were ordered for Resident #30. The orders stated, Patient to have palm posey/protector daily to prevent skin breakdown on bilateral hands 2-4 hours. and Bilateral upper extremity palm guards for 6-8 hours daily. Two observations by the State Surveyor for no right palm protector occurred on 02/10/25 and 02/11/25. On 02/11/25 10:45 AM, duplicate orders for bilateral posey palm protectors wearing schedule with different times for Resident #30 were confirmed by Licensed Practical Nurse (LPN) #39. LPN #39 was unable to state palm protector wearing schedule when asked by the State Surveyor. LPN #39 stated, I'm not sure .I would have to look at the order.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49751 Based on observations and staff interview, the facility failed to ensure they ahdered to safe and sanitary infection control practices. Direct care staff member was observed throwing a soiled brief and linens on a fall mat that was lying on the floor in the resident's room. This was a random opportunity for discovery during the Long - Term Care Survey process Resident identifier: #46. Facility census: 80. Findings included: a) Resident #46 02/10/25 11:32 AM the surveyor observed Resident #46 being provided ADL care by Nurse Aide (NA) #75 behind the curtain. The surveyor waited outside the doorway and noticed a soiled brief was placed on the fall mat on the left side of the bed by NA #75. The fall mat was lying on the floor. 02/10/25 11:36 AM Unit manager Registered Nurse (RN) # 71 was coming down the hall by the surveyor. The surveyor asked about the brief and now soiled linens that were observed placed on the fall mat by NA# 75. RN# 71 went into the room and saw the soiled brief and soiled wash cloths were on the fall mat. RN #71 came back to the door to this surveyor and stated They(NA's) should not be placing any soiled items on the bare floor.