STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366095	A. Building B. Wing	11/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenwood Care and Rehabilitation	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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42013 Based on observation, interview, record review, and review of facility policy, the facility failed to ensure Resident #37's wheelchair was in good repair. This affected one resident (Resident #37) out of three residents reviewed for wheelchairs in good repair. Findings include: Review of Resident #37's medical record revealed an admitted [DATE] and diagnoses included schizoaffective disorder, bipolar type, obesity, and chronic pain syndrome. Review of Resident #37's Quarterly Minimum Data Set (MDS) 3.0 assessment revealed Resident #37 was cognitively intact and required supervision of staff with set up help only for bed mobility, transfers, and toilet use. Resident #37 used a wheelchair. Review of Resident #37's care plan revised, 06/07/21, included Resident #37 was at risk for impaired skin integrity related to confined to a chair all or most of the time, depression, edema, impaired cognition, incontinent of bladder, pain, venous ulcers, and morbid obesity. Resident #37 refused to sleep in bed at times, slept in his wheelchair. Observation on 11/14/22 at 12:09 P.M. with Resident #37 of his wheelchair revealed the left arm of the wheelchair had loose padding and sharp metal pieces under the loose padding. Resident #37 stated he could not get anyone to fix his wheelchair, it was dangerous because he grabbed the left arm for transfer and he could be cut badly by the sharp metal pieces. Resident #37 indicated the wheelchair had been broken about a month and he told therapy about it. Resident #37 stated he did not remember who he told in the therapy department about the broken arm of his wheelchair. Observation on 11/15/22 at 1:03 P.M. of Resident #37's wheelchair revealed the left arm of the wheelchair had loose padding and exposed sharp metal pieces under the loose padding. Interview on 11/15/22 at 2:10 P.M. with Physical Therapist (PT) #574 revealed she did not know which wheelchair Resident #37 was using right now. PT #574 stated a new wheelchair was ordered and in the facility for Resident #37's mobility and positioning, and he had an older wheelchair also. PT #574 stated she did not know the arm of Resident #37's wheelchair was broken and she would look into which wheelchair it was. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/15/22 at 2:36 P.M. with PT #574 revealed Resident #37 was using the old wheelchair because the new wheelchair would not fit in the bathroom, and it was being modified so Resident #37 could use it in the bathroom. PT #574 confirmed the old wheelchair left arm padding was loose with exposed sharp metal pieces under the loose padding. PT #574 stated she replaced the arm and padding of the old wheelchair. Interview on 11/16/22 at 10:14 A.M. of Occupational Therapist (OT) #575 revealed he tried to monitor residents wheelchairs and equipment and when equipment was noted to be in disrepair he would make sure it was fixed. OT #575 stated he did not know Resident #37's wheelchair had loose padding on the left arm with exposed sharp metal pieces and he did not remember Resident #37 telling him it was in need of repair.

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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** 42013 Based on observation, interview, record review, and facility policy the facility failed to ensure Resident's #31 and #232 had physician orders for oxygen administration. This affected two resident's (Resident's #31 and #232) out of three residents reviewed for oxygen orders. Findings include: 1. Review of Resident #232's medical record revealed an admitted [DATE] and diagnoses included chronic respiratory failure with hypoxia, centrilobular emphysema, and chronic obstructive pulmonary disease with acute exacerbation. Review of Resident #232's Admission Evaluation dated 11/11/22, revealed Resident #232 was lethargic and oriented to person and place. Further review of the Admission Evaluation revealed Resident #232 had shortness of breath and used oxygen at four liters via nasal cannula. Review of Resident #232's progress notes dated 11/11/22 at 7:30 P.M. revealed the resident arrived to the facility at 7:30 P.M. and was on oxygen therapy at four liters per minute via nasal cannula. Review of Resident #232's medical record revealed oxygen saturations were documented on 11/11/22 at 7:30 P.M. of 90 percent oxygen saturation on oxygen via nasal cannula, on 11/12/22 at 10:48 P.M. oxygen saturation was documented at 93 percent oxygen saturation on oxygen via nasal cannula. Review of Resident #232's physician orders from 11/11/22 through 11/14/22 did not reveal orders for oxygen administration or orders for care and set up of oxygen tubing. Review of Resident #232's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 11/11/22 through 11/14/22 did not reveal documentation oxygen was administered at four liters per minute via nasal cannula. Review of Resident #232's care plan dated, 11/12/22, included Resident #232 had impaired respiratory status. Resident #232 would be free of complications related to chronic obstructive pulmonary disease, emphysema through next review. Resident #232 would be free of signs and symptoms of hypoxia through next review. Resident #232 would have adequate oxygenation as evidenced by no shortness of breath through next review. Interventions included to administer medications as ordered, monitor for effectiveness and report adverse side effects to physician; monitor for signs and symptoms of respiratory distress and report to physician (increased respirations, low oxygen saturations); provide oxygen as needed when residented exhibits signs and symptoms of difficulty breathing. Observation on 11/14/22 at 4:16 P.M. of Resident #232 revealed she was sitting in a chair in her room, was wearing a nasal cannula, and oxygen was being administered at four liters per minute via nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 11/14/22 at 4:16 P.M. with Licensed Practical Nurse (LPN) #573 confirmed Resident #232 did not have physician orders for oxygen administration. LPN #573 stated Resident #232 was admitted Friday 11/11/22, the hospital told the facility Resident #232 required oxygen to be administered at four liters per minute via nasal cannula. LPN #573 indicated Resident #232's admitting nurse must have forgotten to put the oxygen order in the electronic record. LPN #573 stated she would contact Resident #232's physician to obtain oxygen orders. Review of the facility policy titled, Oxygen Administration, revised, 10/2010, included the purpose of this procedure was to provide guidelines for safe oxygen administration. Verify there was a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident. 2. Review of Resident #31's medical record revealed an admitted [DATE], a re-entry date of 10/06/15, and diagnoses included chronic obstructive pulmonary disease, pneumonia and schizoaffective disorder, bipolar type. Review of Resident #31's care plan, revised 08/01/22, revealed Resident #31 had an impaired respiratory status related to chronic obstructive pulmonary disease (COPD), emphysema, current smoker. Interventions included oxygen as ordered by physician; provide oxygen as needed when resident exhibits signs/symptoms of difficulty breathing (short of breath, cyanosis, low oxygen saturations). Review of Resident #31's Quarterly Minimum Data Set (MDS) 3.0 assessment, dated, 09/02/22 revealed Resident #31 was cognitively intact. Further review of the MDS assessment did not reveal Resident #31 was administered oxygen. Review of Resident #31's physician orders from 09/02/22 through 11/15/22 did not reveal orders for oxygen administration. Review of Resident #31's medical record on 11/07/22 at 10:41 P.M. revealed documentation of an oxygen saturation of 94 percent on oxygen via nasal cannula. Observation on 11/15/22 at 1:27 P.M. of Resident #31 revealed resident was lying in bed sleeping, and an oxygen nasal cannula tubing was laying on the floor next to his bed. Resident #31's oxygen condenser was set at three liters per minute via nasal cannula and oxygen was being administered into the air. Interview on 11/15/22 at 1:33 P.M. of LPN #523 confirmed Resident #31's oxygen tubing was laying on the floor and the oxygen condenser was set at three liters per minute via nasal cannula and was administering oxygen into the air. LPN #523 stated he thought Resident #31's oxygen order was two liters per minute via nasal cannula and would check his physician orders. LPN #523 checked Resident #31's physician orders, stated Resident #31 did not have physician orders for oxygen administration, and he would call Resident #31's physician to obtain orders for oxygen administration. LPN #523 indicated Resident #31 was not always compliant with care and would throw his oxygen tubing on the floor routinely. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, Oxygen Administration, revised, 10/2010, included the purpose of this procedure was to provide guidelines for safe oxygen administration. Verify there was a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39968 Based on medical record review, staff interview, and review of facility Hospice Visit Notes, the facility failed to ensure Hospice services were thoroughly documented to maintain sufficient communication between the facility and Hospice to meet the needs of Resident #45. This affected one Resident (#45) of two reviewed for Hospice services. Findings include: Review of the medical record for Resident #45 revealed an admitted [DATE]. Resident #45's diagnoses included Alzheimer's disease, drug induced secondary Parkinsonism, paraplegia, acute respiratory failure, diabetes, chronic congestive heart failure, unspecified protein-calorie malnutrition, dementia with behavioral disturbances, major depressive disorder, metabolic encephalopathy, schizoaffective disorder, hallucination, chronic pain, fibromyalgia, and anxiety. Review of Resident #45's physician orders revealed she was admitted to Hospice on 07/15/22 for a diagnosis of Alzheimer's disease. Review of Hospice Aide Visit Notes revealed no notes were completed for Resident #45. Review of Hospice Interdisciplinary Team Visit Note, used by registered nurses, social workers and chaplains, were dated and signed but contained no information about what the Hospice staff had done for Resident #45. Review on 11/15/22 at 1:35 P.M. with LPN #545 of Resident #45's electronic medical record revealed no hospice notes had been entered or uploaded to her chart. Interview on 11/15/22 at 1:35 P.M. with Licensed Practical Nurse (LPN) #545 in review of the notes in the Hospice paper chart binder revealed LPN #545 could not tell what care had been given by the hospice staff. Interview on 11/16/22 at 5:10 P.M., Director of Nursing (DON) #530 verified Resident #45's medical record and Hospice binder did not contain any documented communication between Hospice and facility staff. Review of contract between the facility and Hospice, dated on 10/19/17 by all parties, stated communication would be maintained between both parties.