STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075313	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gladeview Health Care Center	60 Boston Post Rd Old Saybrook, CT 06475

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) reviewed for misappropriation of medication, the facility failed to ensure narcotic medications were removed from the medication cart following the resident's discharge which led to the medication going missing from the medication cart. The findings include:Resident #1's diagnoses included aftercare following joint replacement surgery and right knee joint prothesis. The admission Evaluation dated 8/7/25 identified that Resident #1 was oriented to person, place, time and situation and reported no pain on admission. The Resident Care Plan dated 9/12/25 identified that Resident #1 had an alteration in comfort due to post operative surgery and chronic right knee pain. A physician's order dated 9/12/25 directed to administer oxycodone 5 milligram (mg) tablet by mouth every four (4) hours as needed for severe pain. The Facility Reported Incident form dated 9/26/25 identified at 11:00 AM during the Director of Nursing's (DON) bi-monthly narcotic count, two (2) blister pack cards of oxycodone were prescribed for Resident #1 were unaccounted for as well as the white disposition sheets associated with the two (2) cards of oxycodone that get signed off by nursing when the medication is administered. The Facility Reported Incident form identified that all facility medication carts were searched, nurses assigned to that medication cart were interviewed and the Advanced Practice Registered Nurse (APRN) was contacted and reported the oxycodone had been discontinued prior to discharge. The report identified that an agency Licensed Practical Nurse (LPN) #1, who was working the day shift on 9/26/25, was alleged to have taken the two (2) cards of oxycodone and the police and Connecticut Drug Control Division were notified. Review of the clinical record identified Resident #1 was discharged from the facility on 9/25/25 on the 7AM-3PM shift. The investigation identified in a review of the Controlled Substance Disposition Records identified thirty (30) oxycodone 5 mg tablets were received by the facility on 8/7/25 and thirty (30) oxycodone 5 mg tablets were received by the facility on 9/13/25 for a total of sixty (60) oxycodone 5 mg tablets. Review of the August and September 2025 Medication Administration Records (MAR's) identified that only eight (8) oxycodone 5 mg tablets were administered to Resident #1 between 8/7/25 and 9/25/25, leaving fifty-two (52) tablets unaccounted for. Review of the schedule identified LPN #1 was assigned to Resident #1's unit on 9/26/25 on the 7AM-3PM shift. Review of the Connecticut Drug Control report dated 10/28/25 identified in a written statement LPN #2 stated that during the 9/25/25 11PM-7AM shift, the controlled substance count was correct, and she questioned why the oxycodone for Resident #1 was in the narcotic box inn the medication cart if Resident #1 had been discharged earlier in the day. The report indicated LPN #1 worked the 7AM-3PM shift on 9/26/25 and the Director of Nursing conducted her bi-monthly audit of the narcotics on 9/26/25 between 10-11AM. Review of camera surveillance screenshots and interview with the Director of Nursing (DON) on 11/20/25 at 10:57 AM identified LPN #1 arrived for his shift on 9/26/25 at 7:06 AM. LPN #1 can be seen exiting the building to the back parking lot at 9:43 AM and then returning at 10:01 AM. Although LPN #1 cannot be seen holding any blister packs of medication, the DON reported that at the time he was seen exiting the building, most nurses are still passing medications and do not have time to take a break. The DON identified LPN #2 (11-7 shift) reported counting the two (2) cards of Resident #1's oxycodone 5 mg tablets with LPN #1 on 9/26/25 just after 7:00 AM. The DON reported to have arrived on Resident #1's unit and start to complete her bi-monthly narcotic audits around 10:30 AM and then at around 11:00 AM, when she attempted to match the yellow disposition sheets for the oxycodone 5 mg tablets to the white disposition sheets on the cart, she identified that neither the white disposition sheets or the two (2) blister packs of oxycodone 5 mg were on the cart or able to be located so she initiated an investigation. Interviews on 11/20/25 with LPN #2 (11PM-7AM shift 9/25/25 into 9/26/25), LPN #3 (3PM-11PM shift on 9/25/25) and LPN #4 (7AM-3PM shift on 9/25/25) identified they did not remove Resident #1's oxycodone 5 mg tablets from the cart and recalled counting the oxycodone 5 mg tablets during their shift change narcotic count for the three (3) shifts prior to the medication going missing on 9/26/25 and both the oxycodone and disposition sheets were present in the medication cart. LPN #4 identified Resident #1 was discharged towards the end of her 7AM-3PM shift on 9/25/25 and although she would usually request the DON take the narcotics of any discharged residents or discontinued medications, she did not see the DON that shift, so the oxycodone cards remained locked in the medication cart. LPN #2 identified she recalled questioning LPN #3 when she (LPN #2) arrived for her shift at 11:00 PM on 9/25/25 as to why the oxycodone cards were still in the medication cart despite Resident #1 being discharged during the day on 9/25/25. LPN #3 confirmed that LPN #2 questioned her as to why Resident