Printed: 09/27/2024
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185363	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glasgow State Nursing Facility	207 State Avenue Glasgow, KY 42141

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44370 Based on interview, record review and review of facility's policy, the facility failed to implement the care plan for one of nine sampled residents (Resident #1) R1. The facility assessed R1 as a high risk for wandering and developed a care plan with interventions that addressed that behavior. The facility failed to ensure the care plan interventions were implemented. On 06/24/2024 at 6:09 AM, R1 exited Pod 2 (where he resided), a secured unit, behind a kitchen staff member, who did not ensure the door was secured after going through the doors. A Housekeeper passed R1 in the hall; the Housekeeper failed to intervene. R1 proceeded to the front lobby where the Security Guard was stationed and also failed to intervene when R1 went out the front door. A Registered Nurse (RN) on her way to work, observed R1 walking on the sidewalk near the end of the street, and notified the facility at 6:20 AM of that information. R1 was approximately 0.6 miles from the facility when the RN observed him. R1 exited the front door at 6:09 AM and was returned to the facility at 6:31 AM. The facility's failure to have an effective system in place to ensure each resident's care plan interventions were implemented to prevent elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 07/08/2024 and was determined to exist on 06/24/2024 in the area of 42 CFR 483.21 Comprehensive Resident Centered Care Plan, F656. The facility was notified of the Immediate Jeopardy on 07/08/2024. The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on 07/10/2024, alleging removal of the IJ on 06/25/2024. An Extended Survey was initiated on 07/10/2024, and the State Survey Agency (SSA) validated the facility's IJ Removal Plan on 07/10/2024. The SSA validated the immediacy of the IJ had been removed on 06/25/2024, as alleged. Therefore, the IJ was determined to be Past IJ. Further the SSA determined the facility was in substantial compliance on 07/02/2024. The findings include: (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: 185363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glasgow State Nursing Facility	207 State Avenue Glasgow, KY 42141

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy titled, MDS 3.0 Assessment: Nursing Care Plans, dated 01/31/2020, revealed each resident was to have an individualized interdisciplinary care plan based upon his or her immediate needs and individual preferences when appropriate. Continued review revealed successful implementation of the care plan involved three closely related activities: communicating the care plan; administering the care; and coordinating all patient (resident) care. Review further revealed all direct care staff were accountable for complying with all interventions outlined in the resident's plan of care. Review of the closed record, Face Sheet and History and Physical, dated 03/25/2024 for R1 revealed the facility admitted the resident on 03/14/2023, with the following diagnoses: polysubstance abuse disorder, chronic schizophrenia, and neurocognitive disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 05/07/2024, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of eight out of 15. This score indicated R1 was moderately cognitively impaired. Review of the facility's,Wander Risk Assessment, dated 04/22/2024 for R1, completed by the Director of Nursing (DON), revealed a score of thirteen (13) which indicated the resident was at high risk for wandering and wander risk precautions were indicated. Review of R1's Comprehensive Care Plan, dated 03/20/2023, revealed the facility care planned the resident as at high risk for wandering. Per review of the care plan, the interventions included: redirecting R1 away from the door and back to his room; ensure all doors were closed securely when entering or exiting the pod (unit); and, observe for the behavior of wandering and redirect as needed. Continued review of the care plan revealed the interventions additionally included: if the resident had been identified as high/moderate wander risk notify all staff to pay attention to R1 and implement increased monitoring utilizing the Increased Monitoring Log as needed (PRN). Further review revealed the goal noted R1 was to remain safely engaged in activity-focused care to decrease wandering. Additional review revealed an intervention dated 05/09/2024, for R1 to be on close observation (in staff's line of sight at all times) from 9:00 PM to 7:00 AM. The incident occurred at 6:09 AM. In an interview with the Security Guard on 07/03/2024 at 9:30 AM, he stated he had never had contact with any residents in the facility, but had been trained on the elopement binders. The Security Guard stated he looked up and saw R1 leaving out the front door wearing a gray shirt. He stated R1 did not say anything to him and just left out the front door. The Security Guard stated he thought R1 was a staff member. He stated he was made aware a resident was missing when a nurse came to the lobby and asked him if he had seen anyone. He stated he told the nurse someone had gone out the front door. In interview on 07/03/2024 at 12:38 PM, the Dietary Aide (who R1 followed out the pod door on 06/24/2024) stated when he exited the pod on 06/24/2024, he had not ensured the door was closed in his hurry to get back to the kitchen. The Dietary Aide stated he should not have left the area until the doors had been secured. He stated he had not seen R1 exit through the door after him, and only learned of a missing resident when someone paged it overhead. The Dietary Aide stated the DON came to the kitchen that day and did a quick in-service with dietary staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Glasgow State Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 207 State Avenue Glasgow, KY 42141	

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 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In interview on 07/03/2024 at 12:46 PM, Nurse Aide State Registered #1 (NASR1) stated R1 had been care planned as a high wander risk with interventions and that information was in the facility's Resident ID (Identification) Binder. She stated R1 typically stayed in his room during the night, but sometimes sat in a chair by his room door. In interview on 07/08/2024 at 2:51 PM, NASR6 stated on R1's care plan it said he was a high wander risk, but she had not observed the resident wandering on the unit. She stated R1 had been on close observation from 7:00 AM until 9:00 PM prior to him getting out the pod doors. However, he was not on close observation at the time of exiting the pod. [NAME] 6 said close observation meant the resident was to be in their sight at all times. In interview on 07/05/2024 at 8:58 AM, the MDS Coordinator stated residents' care plans were printed with the annual or a significant change MDS Assessments. She stated the care plans were in a binder at each nurses' station and she updated the printed care plans as changes occurred. The MDS Coordinator further stated interventions had been in place for R1 and staff knew to make sure the pod doors were closed before leaving the area. In interview on 07/10/2024 at 1:42 PM, the Director of Nursing (DON) stated her expectations were for residents' care plans to be implemented and followed as required. She stated staff were aware they were not to leave the pod area until the doors closed. The DON stated she expected whoever was working the front desk to be observing the facility's security camera monitor. She stated a policy revision had been completed and all staff had been re-educated on the policy. The DON stated dietary staff were not aware of what was on a resident's care plan, but all staff had been trained on ensuring the pod doors were closed before leaving the area. In interview on 07/10/2024 at 2:14 PM, the Facility Director stated her expectations were for staff to ensure resident safety. She stated R1 was care planned as a wander risk and she expected the resident's care plan interventions to be followed. The DON stated if residents were outside of the pod area without staff, then staff were to always stay with the resident, keep them in sight, and call for assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glasgow State Nursing Facility	207 State Avenue Glasgow, KY 42141

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 - Immediate jeopardy to resident health or safety

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44370

Based on observation, interview, record review, facility document and policy review, and Google Maps, the facility failed to provide effective monitoring and supervision to prevent elopement for one (1) of nine (9) sampled residents assessed for high elopement risk Resident #1 (R1).

The facility assessed R1 as being at risk for wandering and care planned the resident for being a wandering risk. R1's care plan interventions included: ensuring all doors were closed securely when entering or exiting the resident's pod (unit), redirecting the resident away from doors, and observing for wandering behavior with redirection as needed.

However, on 06/24/2024, facility staff failed to follow the resident's care plan interventions and allowed R1, who ambulated independently, to exit the facility without staff's knowledge at 6:09 AM. R1 was located by a staff person, walking on the sidewalk down the street, 0.6 miles from the facility. The staff notified the facility at 6:20 AM.

The facility's failure to have an effective system to ensure each resident received adequate supervision and monitoring to prevent elopement has caused or is likely to cause serious injury, harm, impairment, or death to a resident.

Immediate Jeopardy (IJ) was identified on 07/08/2024 and was determined to exist on 06/24/2024 in the area of 42 CFR 483.25 Quality of Care, F 689 at a Scope and Severity (S/S) of a J. Substandard Quality of Care (SQC) was also identified at 42 CFR 483.25 Quality of Care, F689. The facility was notified of the Immediate Jeopardy on 07/08/2024.

An acceptable Immediate Jeopardy (IJ) Removal Plan was received on 07/10/2024, alleging removal of the IJ on 06/25/2024. An Extended Survey was initiated on 07/10/2024, and the State Survey Agency (SSA) validated the facility's IJ Removal Plan on 07/10/2024, and determined the deficient practice was corrected as alleged on 06/25/2024. Therefore, the IJ was determined to be Past IJ. Further the SSA determined the facility was in substantial compliance on 07/02/2024.

The findings include:

Review of the facility's policy titled, Safe Environment, dated 06/14/2023, revealed the purpose of the policy was to describe the (facility's) responsibilities related to the protection of its individuals. Continued review revealed elopement, was an event in which an individual had not been accounted for when expected to be present or had left the facility grounds without permission.

Review of the facility's policy titled, Wander Risk Precautions, dated 08/29/2016 and revised on 06/24/2024 (the day of R1's elopement), revealed it was the facility's policy to identify residents who walked or wheeled about unrestricted and were at risk to leave the facility unattended without staffs' knowledge. Further review revealed a wander risk assessment was to be completed on all residents at admission, quarterly, and with any significant change.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Glasgow State Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 207 State Avenue Glasgow, KY 42141	

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Face Sheet and History and Physical, dated 03/25/2024, located in the closed medical record, revealed the facility admitted R1 on 03/14/2023. R1's diagnoses included: chronic schizophrenia, neurocognitive disorder, and polysubstance abuse disorder. Review of the Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 05/07/2024, revealed the facility assessed R1 to have a Brief Interview for Mental Status (BIMS) score of eight out of 15. This score indicated the resident had moderate cognitive impairment. Review of the facility's Wander Risk Assessment, dated 04/22/2024, completed by the Director of Nursing (DON) for R1 revealed a score of thirteen (13) which indicated the resident was a high risk for wandering and wander risk precautions were indicated. R1 was not observed or interviewed as he/she had been transferred to a State Psychiatric Hospital on 06/25/2024. Observation on 07/05/2024 at 9:50 AM, of Pod 2 (a men's only unit) revealed the resident's room was located directly across from the nurse's station and approximately 21 steps to the exit door. Continued observation revealed the pod had automatic doors and could only be accessed using a facility-designated badge. Further observation revealed both of the pod doors opened once a badge was used and the open-door button was pushed. Review of the facility's investigation dated 06/24/2024, revealed on that date at 6:09 AM, R1 exited Pod 2 a secured unit, behind a kitchen staff member, who had not ensured the pod door was secured. Per review, a housekeeper passed R1 in the hall and asked where he was going, and he gave no response. Continued review revealed the housekeeper failed to intervene, and R1 proceeded to the front lobby where security personnel further failed to intervene when R1 went out the front door. Review of the facility's investigation also revealed a Registered Nurse (RN) on her way to work, observed R1 walking on the sidewalk near the end of the street the facility was located near a car dealership lot. Further review revealed R1 was approximately 0.6 miles from the facility. RN1 notified the facility at 6:20 AM of the resident's location. R1 exited the front door at 6:09 AM and was returned to the facility at 6:31 AM with no injuries noted. The SSA Surveyor drove to the location where RN1 first saw R1, (the route was also verified by Google Maps) was noted to be 0.6 miles from the facility. Google Maps indicated was a 13 minute walk. Review of the Underground weather website revealed the air temperature (temp) on 06/24/2024 at 6:00 AM was 64 degrees Fahrenheit (F). Review of the facility's video camera clip 1 revealed on 06/24/2024 at 6:07 AM, a dietary aide entered the secured unit (R1's pod) to deliver clean water pitchers. Continued review of the video camera clip 1 revealed at 6:09 AM, the dietary aide exited the unit and failed to wait for the door to secure. R1 stopped the door from closing all the way, waited about three seconds and opened the door and exited the unit in a rushed manner. Additional review revealed R1 had been wearing a long-sleeved gray shirt, blue pants, and tennis shoes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER Glasgow State Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 207 State Avenue Glasgow, KY 42141	

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's video camera clip two (2) revealed on 06/24/2024 at 6:09 AM, R1 could be observed entering the facility's lobby area and exiting out the front door. Further review of video camera clip 2 revealed a security guard sitting at the front desk, who did not intervene and allowed R1 to exit the facility. Review of the facility's video camera clip three (3) revealed on 06/24/2024 at 6:31 AM, R1 was returned to the facility accompanied by 2 staff members. In interview with the Security Guard on 07/03/2024 at 9:30 AM, he stated he had been employed as the facility's night shift security guard for approximately four months. He stated his primary duties were to stay at the desk and answer the phones and watch the door. The Security Guard stated he received training during orientation, and had been made aware of the elopement binders. During the interview, he stated he had never had contact with any of the residents living in the facility, and had not done rounds on the units. He stated he did not know what side of the building R1 had came from and he looked up and saw the resident leaving out the front door. The Security Guard stated R1 had on a gray shirt when he exited the facility and that was all he could recall. He stated R1 had not said anything and just left out the front door. The Security Guard stated he thought the person (R1) leaving was a staff member, and anyone could get out the doors, but he had to let people in. He stated he was made aware a resident was missing when a nurse, whose name he did not know, came to the lobby and asked him if he had seen anyone. He stated he told the nurse someone had left out the front door. The Security Guard stated he was terminated that same day for letting R1 out the front door. In interview with the dishwasher (dietary staff personnel) on 07/03/2024 at 12:38 PM, he stated he had taken the bus carts to Pod 2, and when he exited the pod he did not ensure the door was latched as he was in a hurry to get back to the kitchen as tray line was starting. He stated he did not see R1 exit through the door; however, he should have ensured the door was closed before leaving the pod area. The dishwasher stated he only learned of a resident missing when someone paged that information overhead. He further stated the DON did a inservice with dietary staff that same day (06/24/2024). During an interview with Nurse Aide State Registered #1 (NASR1) on 07/03/2024 at 12:46 PM, she stated R1 typically stayed in his room during the night and sometimes he would sit in a chair by his room door. She stated R1 was independent with ambulation. NASR1 stated she and NASR2 were doing AM (morning) care, getting people up, and making beds when she saw R1 sitting in a chair by his door. She stated around 6:20 AM, the nurse had them do a head count and it was discovered R1 was gone. The [NAME] stated she left the pod to look for R1, and when in the lobby area she asked the security guard if he had seen a man. She said the security guard told her a man had gone out the front door. She stated she and Administrative (Admin1) Staff 1 went out the front door and checked the grounds; however, they did not see R1. In interview with RN1 on 07/03/2024 at 2:26 PM, she stated she was driving to work on 06/24/2024, and when she turned onto a side street she saw a man walking and realized it was R1. She stated she immediately called the facility and when she checked the time her phone was at 6:20 AM. RN1 stated she turned around and pulled into the parking lot of a closed business and shouted at R1 to get his attention, who was near the bottom of a hill near a car dealership. She stated she got R1's attention and started walking towards him and he started walking towards her. The RN stated she and R1 waited in the parking lot for other staff to arrive. She further stated R1 never said a word and she did not ask where he was going or what he had been doing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glasgow State Nursing Facility	207 State Avenue Glasgow, KY 42141

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	In interview with Licensed Practical Nurse #1 (LPN1) on 07/03/2024 at 3:00 PM, he stated he had been the nurse on duty on the day R1 exited the facility (06/24/2024). He stated R1 had been quiet with no concerns throughout the night. The LPN stated at 6:10 AM, he was in the kitchenette getting coffee ready for the residents when housekeeping staff informed him she had seen a resident in the hall. He stated he immediately left the pod and looked on both the halls leaving Pod 2 and he had not seen any residents. LPN1 stated he returned to the pod and had NASR1 and NASR2 do a head count of residents. Per interview with LPN1, NASR1 informed him R1 was not on the unit, so he notified RN2. RN2 paged the missing resident over the intercom. He stated he took the call from RN 1 stating she had seen R1 walking down the street on the sidewalk and was with the resident at a closed business down the street. LPN1 stated he informed RN2 of that information, and he (LPN1) and the Staff Development Coordinator (SDC) got in his car and went to pick R 1 up. He further stated R1 got in the car without incident, and when he asked R1 if he was okay the resident replied he had just wanted to go out for a walk. During an interview with the SDC on 07/03/2024 at 3:40 PM, she stated she had arrived to work and saw a staff member in the parking lot who told her R1 was missing. She stated she entered the facility's side door and went to the front desk where RN1 was on the phone with law enforcement saying R1 had been located. The SDC stated she and LPN1 drove down the street to pick R1 up, and when she asked the resident if he was okay he started to cry a little and said he wanted to go home. She stated R1 got in the car with no problem, walked in the facility and to his pod and sat down. The SDC stated during orientation the elopement binders were shown to new staff and discussed. She further stated all staff, to include contract staff, received the orientation and training on the elopement binders. In interview with the Housekeeper on 07/05/2024 at 10:19 AM, she stated she had been working on 06/24/2024, when R1 left the facility. She stated she had been on Pod 2 around 6:00 AM and saw R1 sitting in a chair outside his room door. The Housekeeper stated residents were not supposed to be in the hall without a staff member. She stated she had been walking down the hall when R1, almost running, passed her. The Housekeeper stated housekeeping staff were not to physically touch residents, and were to report concerns to the nurse. The Housekeeper stated she asked R1 where he was going, but he just kept walking fast. She said she knew R1 was a resident; however, she did not known his name. The Housekeeper stated she went to Pod 2 and told the nurse she had seen a resident in the hall and the nurse stopped what he was doing and went and checked the hall. She further stated she then returned to what she had been doing, but learned the next day, from the DON, she should have kept R1 in her sight. During interview with RN2 on 07/05/2024 at 10:55 AM, he stated he had arrived to work at 5:45 AM, the morning of R1's elopement, and had been in the office working when he heard fast-paced foot steps. He stated NASR6 had been in the hall and told him R1 was missing. The RN stated he went to the front desk, reviewed the Resident Identification (ID) Binder and called 911. He stated RN1 called and said she was with R1 in a parking lot, and he (RN2) had LPN1 and the SDC go pick the resident up. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2024
NAME OF PROVIDER OR SUPPLIER: Glasgow State Nursing Facility		STREET ADDRESS, CITY, STATE, ZIP CODE: 207 State Avenue Glasgow, KY 42141	

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	During interview with the Facility Services Supervisor (Risk Manager) on 07/05/2024 at 1:24 PM, she stated she was responsible for the security staff members. She stated the Security Guard present when R1 exited the facility, had been working at the facility about six months. The Facility Services Supervisor stated she was unsure what qualifications the Security Guard had when employed and would have to look at his file to see. She stated all staff were made aware of the Resident Identifier Reports binder when hired, and the SDC provided orientation for the new hires. The Facility Services Supervisor further stated the Security Guard said he thought the man (R1) was an employee. In addition, she stated the Security Guard had been terminated on 06/24/2024, for letting a resident leave out the facility's front door. In interview with NASR6 on 07/08/2024 at 2:51 PM, she stated she had been working the morning R1 left the facility. She stated housekeeping had cleaned the beds on the unit and she and NASR1 were getting residents up and making their beds. NASR6 stated R1 seldom came out of his room, but when he did he sat in a chair by his door. She stated she had been making a bed when [NAME] 1 told her they needed to do a headcount of residents. The [NAME] said she checked rooms and closets and NASR1 reported R1 was not on the unit. In interview with the DON on 07/10/2024 at 1:42 PM, she stated she had been on her way to the facility on [DATE], when she received a phone call informing her R1 had eloped. She stated she called the Facility Director, and facility staff followed protocol in locating a missing resident. The DON stated the facility's investigation showed the dietary aide failed to ensure the Pod 2 door was secure before walking away, which allowed R1 to exit the pod. She stated when R1 entered the lobby the Security Guard, who should have been watching the camera monitors, allowed the resident to exit the facility thinking R1 was a staff member. The DON stated the Security Guard was terminated and she sent paperwork in to initiate disciplinary action for the dietary aide which was pending due to the State's process regarding disciplinary actions. She stated she did not think there were potential adverse outcomes for R1 as he knew to stay on the sidewalk. The DON stated R1 made a calculated decision and knew what he was doing. During interview with the Facility Director on 07/10/2024 at 2:14 PM, she stated the DON had made her aware of R1 exiting the facility. She stated R1 was returned to the facility when she arrived. The Facility Director stated the facility followed its policy and protocol for Missing Resident. She stated the facility initiated an investigation and it was determined the dietary aide's and Security Guard's failure to intervene, which allowed R1 to leave out the front door, were the root cause of the event. The Facility Director stated staff were aware of the elopement binders on each Pod and lobby area. The Facility Director stated if residents were outside of the pod without staff then staff were to stay with the resident at all times, keep them in sight, and call for assistance. She stated the facility had an AdHoc (unplanned meeting for a special purpose) Quality Assurance Performance Improvement (QAPI) meeting with the Medical Director, after R1's elopement, to discuss the incident and put a plan in place to complete education and training and develop tools for monitoring. She stated her expectations were for staff to ensure residents' safety.