

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 515118	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/29/2024
NAME OF PROVIDER OR SUPPLIER Glasgow Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Melrose Drive, Box 350 Glasgow, WV 25086	

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)
<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39571</p> <p>Based on resident interview, record review and staff interview the facility failed to promote and facilitate resident self-determination through support of resident choice, and to ensure residents rights for self-determination was encouraged. This was true for two (2) residents and was a random opportunity for discovery. Resident identifiers: # 95 and #99. Facility 99.</p> <p>Findings include:</p> <p>a) Resident #95</p> <p>Resident #95 is a [AGE] year-old male, who has capacity and is a Paraplegic.</p> <p>While reviewing a report it was discovered Resident #95 had kissed Resident #99 at the nurses' station on the mouth. The nursing notes stated Residents were separated and educated on inappropriate behavior. DON (Director of Nursing), administrator, and management on call notified. This note was written at 8:53 PM on 03/30/24.</p> <p>The reportable note stated, Nurse separated both easily redirected and placed on 15-minute checks and skin assessments and both residents stated they consented for the kiss, however, the other resident lacks capacity to consent.</p> <p>The above nursing notes and reportable were signed by Licensed Practical (LPN) #24.</p> <p>On 03/31/24 at 8:50 PM:</p> <p>Nurses Note read as below:</p> <p>Note Text: Patient observed in wheelchair behind curtain in dark room in (named Resident #99) room. Patient asked to vacate patient's room. Patient education preformed on inappropriate behavior. Primary nurse notified at this time.</p> <p>Further review of the facility reportable found statements from multiple staff saying Residents #95 and #99 have for months ate lunch and dinner together and attend activities together and holding hands a lot.</p> <p>(continued on next page)</p>

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 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 04/23/24 at 12:30 PM with Resident #95. The resident reported he and Resident #99 were dating. He stated he had not been told that he could not have a relationship with another resident. Resident #95 reported he had been sitting in his wheelchair talking to Resident #99 in her room and staff told him it was against facility rules. Residents stated this made him feel as if he was doing something wrong.</p> <p>b) Resident #99</p> <p>Resident #99 is a [AGE] year-old female who lacks capacity, due to having a stroke. Her brief interview of mental status (BIMS) score was an 11 which indicates her cognitive function was moderately impaired.</p> <p>Resident #99 was seen receiving a kiss on the mouth at the nursing station on 03/30/24 at 8:50 PM. At the time of the kiss Resident #99 said she welcomed the kiss; this was found in a nursing note in the reportable.</p> <p>The facility reportable stated at the time of the incident this resident was also placed on 15-minute checks and skin assessments.</p> <p>A review of the nursing notes found the following notes pertaining to this situation:</p> <p>A nurses note dated 03/30/24 by Registered Nurse (RN) #2 at 10:47 PM stated Patient and other resident informed that they needed to stop their activity . Patient education performed. Administrator, DON, manager on call, and provider notified at this time.</p> <p>An interview was completed on 04/23/24 at 11:12 AM, with Resident #99. The resident reported she was never directly told by the facility that she could not have a relationship with another resident. Resident #99 reported that she enjoys the company of Resident #95 and stated several times he has done nothing wrong. Resident #99 reported I'm a grown woman and can have a relationship with anyone I want.</p> <p>c) Interview</p> <p>On 04/24/24 at 2:00 PM an interview with the DON and Administrator found the 15-minutes checks (monitoring residents' movements) were presently still ongoing.</p> <p>The DON was asked how long the residents were above going to remain on the 15-minute checks. The DON stated, she and the Administrator were discussing it today and she decided to continue them for 90 days.</p> <p>The Administrator and DON were asked why the facility was preventing the two (2) residents from having a relationship if both parties want to have a relationship. They both stated that no one was preventing them from having a relationship. They were shown the nursing notes about Resident #95 being vacate her room and was re-educated about appropriateness. It was also noted the residents have not been together during the survey.</p> <p>At the close of the survey on 04/29/24 at 4:30 PM, the residents were never observed together.</p>		

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<p>F 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>50551</p> <p>Based on observation, record review and staff interview the facility failed to ensure the most recent survey was accessible to residents, family members, and legal representatives of residents. This failed practice had the potential to affect more than an isolated number of residents. Facility census: 99.</p> <p>Findings included:</p> <p>a) Survey documentation</p> <p>On 04/22/24 at 3:35 PM, a review of the current Survey Documentation located in the lobby of the facility for public access revealed the survey book did not contain the most recent survey results for November 2023.</p> <p>An interview was conducted on 04/22/24 at 3:50 PM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) who acknowledged the most recent survey was not in the survey binder located in the front lobby for general access. ADON reported he could not locate the current survey results in the facility and stated the Administrator could email the survey results to him from outside of the office.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>39571</p> <p>45174</p> <p>Based on record review and staff interviews the facility failed to ensure residents were free from neglect. Residents #13, #90 and #100 had physician orders for hourly checks for fall prevention. Due to the facility's failure to complete the hourly checks, resulting in the residents continuing to fall. Resident #2 was on 15-minute checks but was able to place himself in the room of a female resident and did not have pants on. Resident identifiers: #13, #90, #100. Facility Census: 99.</p> <p>Findings included:</p> <p>a) Policy Review</p> <p>A review of the facility policy titled Abuse Prevention Program with a revision date on 12/06 reads as follows:</p> <p>Neglect/Deprivation of Goods and Services by Staff (for further information, refer to Identifying Neglect policy)</p> <ol style="list-style-type: none"> 1. Neglect is the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. 2. Neglect occurs when the facility is aware of, or should have been aware of, goods or services that a resident requires but the facility fails to provide them and this has resulted in (or may result in) physical harm, pain, mental anguish or emotional distress. 3. Neglect includes cases where the facility's indifference to or disregard for resident care, comfort or safety results in (or could have result in) physical harm, pain, mental anguish or emotional distress. 4. Neglect may be a pattern of failures or may be the result of one or more failures involving one resident and one staff person. <p>b) Resident #13</p> <p>During a record review on 04/24/24 at 9:00 AM Resident #13's medical records revealed a physician order dated 05/08/23 one-hour checks while the resident was in bed r/t (related to) falls every hour.</p> <p>Further medical record review revealed the following missing one-hour checks:</p> <p>-02/17/24 1:00 PM, 2:00 PM, 3:00 PM, 4:00 PM, 5:00 PM, 6:00 PM</p> <p>-02/21/24 12:00 PM, 1:00 PM, 2:00 PM, 3:00 PM, 4:00 PM, 5:00 PM, 6:00 PM</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-02/28/24 4:00 AM, 5:00 AM, 6:00 AM</p> <p>Further record review revealed an incident note dated 02/27/24 at 2:24 AM (typed as written) CNA Certified Nurse Aide) reported resident found on the floor laying face down on the fall mat. Assessment completed. VS (vital signs) obtained. S/S (signs and symptoms) of pain/ discomfort. Resident yelling out. Skin assessment completed with no injuries noted at this time. Resident unable to describe what happen. Resident stated she hit her head. Assisted CNA with transferring resident back to the bed. CNA provided incontinent care. Contacted on-call physician. Orders received to send resident to ER for further evaluation. Spoke with the local government agency) after hour services regarding the incident. Notified DON(Director of Nursing). Will continue to monitor.</p> <p>During an interview on 04/24/24 at 1:47 PM the DON acknowledged the one-hour checks were not completed and could have contributed to a resident falling.</p> <p>b) Resident #90</p> <p>During a record review on 04/24/24 at 9:15 AM Resident #90's medical records revealed a physician order dated 10/31/22 one-hour checks for fall prevention every hour for Multiple falls.</p> <p>Further medical record review revealed the following missing one-hour checks:</p> <p>-03/25/24 3:00 PM, 4:00 PM, 5:00 PM and 6:00 PM</p> <p>-02/17/24 1:00 PM, 2:00 PM, 3:00 PM, 4:00 PM, 5:00 PM, 6:00 PM</p> <p>-02/21/24 12:00 PM, 1:00 PM, 2:00 PM, 3:00 PM, 4:00 PM, 5:00 PM, 6:00 PM</p> <p>-02/28/24 4:00 AM, 5:00 AM, 6:00 AM</p> <p>Further record review revealed the following incident notes:</p> <p>-04/07/24 11:15 PM (typed as written)</p> <p>Resident found in floor with wheelchair flipped backwards; neuros and Orthosis completed per facility protocol; no injuries observed at this time; resident assisted back to wheelchair per residents request; resident with no voiced c/o pain but does state he hit his head when he fell ; resident wheeled self down hall post fall; intervention: anti tippers to be placed to wheelchair.</p> <p>-3/19/2024 at 8:00 AM (typed as written)</p> <p>Unwitnessed fall- Upon assessment, resident observed to be sitting between his bed and the wall with the bedside table tipped over and halfway under the bed. Pupils equal and reactive. Resident is able to move all 4 (four) extremities without difficulty however is complaining of intermittent lower back pain. PRN (as needed) Tylenol ordered. Resident is currently self-propelling in his wheelchair at baseline. Resident is alert and oriented at baseline with no further complaints. name NP notified. New order received:</p> <p>1. Thoracic spine 2-3 view x-ray</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Lumbar spine 2 view x-ray</p> <p>3. Pelvis 1 view x-ray</p> <p>RP notified and is agreeable with the current plan of care.</p> <p>-03/03/2024 at 4:10 PM (typed as written)</p> <p>Resident yelling out for help. Resident found on the floor laying on his back between his bed and the roommate's bed. Assessment completed. Denies any pain or discomfort. Resident stated he hit his bed on the footboard of the roommate's bed. Skin assessment completed with no injuries noted at the time of the incident. Neuro checks initiated. Orthostatic BP (Blood Pressure) obtained. Resident stated he was trying to put lotion on his thigh and fell back to the floor. Resident was standing inside the doorway at the time of the floor. Wheelchair was not near the resident. Gripper socks on resident properly. Resident transferred to his bed. On-call physician notified with orders received to send to ER (emergency room) for further evaluation. Notified nursing manager on duty. Voicemail left for POA (Power of Attorney). Education provided to the resident regarding using wheelchair as directed and asking for staff assistance when needed d/t impaired gait and weakness. BIMS score of 6.0. Dx (Diagnosis) of unsteadiness on feet and muscle weakness. Safety measures in place with call light in reach. Will continue to monitor.</p> <p>-2/17/2024 11:15 PM (typed as written)</p> <p>Resident reported a fall from prior shift. Assessment completed. AOx3 with periods of confusion. Denies any pain or discomfort. Skin assessment completed with skin tear noted to right front thigh. Resident stated, I fell this morning and a pretty lady helped me up. Education provided on asking for assistance when needed and reporting a fall when incident occurs. Contacted on-call physician and Guardian. Message left from guardian. Neuro checks initiated. Safety measures in place with call light in reach Will continue to monitor.</p> <p>During an interview on 04/24/24 at 1:47 PM the DON acknowledged the one-hour checks were not completed and could have contributed to a resident falling.</p> <p>c) Resident #100</p> <p>During a record review on 04/24/24 at 9:45 AM Resident #100's medical records revealed a physician order dated 01/01/24 one-hour checks for fall prevention every hour for Multiple falls.</p> <p>Further medical record review revealed the following missing one-hour checks:</p> <p>-01/12/24 3:00 AM, 4:00 AM and 5:00 AM</p> <p>-01/27/24 5:00 AM and 6:00 AM</p> <p>Further medical records revealed the following incident note dated 01/26/24 at 10:45AM (typed as written)</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>CNA reported resident was found on the floor, laying on her left side on the floor mat and her upper body leaning on the bed. Assessment completed. VS obtained. Denies any pain or discomfort. Per resident she denies hitting her head and no s/s noted. Skin assessment completed with no injuries, bruises, or open areas noted at the time. Transferred resident back to her bed. Incontinent care provided. Fall precautions in place. Neuro checks initiated. Phy notified and no orders received. Voicemail left with local state agencies APS caseworker. DON made aware.</p> <p>During an interview on 04/24/24 at 1:47 PM the DON acknowledged the one-hour checks were not completed and could have contributed to a resident falling.</p> <p>d) Resident #2</p> <p>A review of facility records found Resident #2 was placed on 02/13/24 at 1:04 AM after having an altercation with the roommate and stating she was leaving.</p> <p>On 02/14/24 at 4:05 PM Resident #2 was discovered in the bed with Resident #57 without any pants on per the reportable documentation from the facility.</p> <p>On 04/23/24 at 5:10 PM, during an interview with the DON the DON confirmed there was an order to start 15-minute monitoring checks on 02/13/24 at 1:04 AM. The DON also confirmed the 15-minute checks have continued since then with no order or plan in place to end the 15-minute checks as of today.</p> <p>On 04/24/24 at 12:10 PM the Administrator was asked if the staff were doing the 15-minute monitoring checks how Resident #2 was not checked on before the event with being in the bed with no pants on happened?</p> <p>Staff statements gathered after the event on 02/14/24 were as follows:</p> <p>-Nurse Aide (NA) #6 stated on 02/14/24, I was in Parlor assisting other residents and had not been in Residents room for about an hour. The last time I saw either resident was around 3 PM at Valentines Party.</p> <p>-NA#40 stated, I was passing ice on hallway and hadn't made it to residents' room. It had been about 20 minutes since I saw them.</p> <p>- Former employee Licensed Practical Nurse (LPN) #114 stated, upon entering room to give patient medication nurse discovered resident and another female resident lying in bed with clothes off from waist down facing each other talking.</p> <p>A review of the 15- minute monitoring check sheet found all 15-minute time slots had initials in every slot.</p> <p>The NA statements revealed they had not visually checked Resident #2 for at least 20 minutes to an hour. This was discussed with the DON on 04/29/24 at 9:10 AM.</p>		

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<p>F 0606</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not hire anyone with a finding of abuse, neglect, exploitation, or theft.</p> <p>39571</p> <p>Based on review of facility documents, staff interview, and interview via phone with the [NAME] Virginia licensing board of nursing. The facility failed to report nurses who had a disciplinary action in effect taken and/or released from their employment at the facility due to unaccounted for or missing controlled medications and not administering medications as ordered, along with falsified documentation about marking a medication as given when it was not given. Resident Identifier: # 101. Facility census: 99.</p> <p>Findings include:</p> <p>a) Resident #101</p> <p>During a review of the facility reportable for an incident which took place on 12/25/23 or 12/26/23, the brief description of the incident was: Narcotic count off. Discrepancy of (liquid) Morphine amount on 12/25/23 at 3:00 PM and discrepancy of Neurontin on 12/26/23 at 3:20 PM.</p> <p>Immediate action taken to protect residents: Count Corrected, Perpetrator suspended pending investigation.</p> <p>This incident was not reported until 12/26/23 at 3:27 PM, even though the first discrepancy occurred on 12/25/23.</p> <p>On 12/25/23 Licensed Practical Nurse #115 was given a Coaching/teachable Moment , by ADON. (This indicates the facility first obtained knowledge of the incident on 12/25/23).</p> <p>Violation did not thoroughly count liquid narcotics.</p> <p>Reason for Warning/Notice: count correction.</p> <p>To avoid disciplinary action, employees should: Visualize each liquid narcotic amounts.</p> <p>This was signed by both LPN#115 and the ADON on 12/25/23.</p> <p>The same form as mentioned above was completed by the DON on 12/26/23.</p> <p>At the top it was handwritten Suspension</p> <p>Violation: Incorrect administration of narcotic</p> <p>Reason for warning/notice: Discrepancy of ordered Morphine sulfate solution on 12/25/23 at 10:30 AM. Narcotic sheet states 3.5 ml available. On 12/25/23 at 2:30 PM the amount available was 0.25 ML. This was visible in bottle per the ADON.</p> <p>(continued on next page)</p>

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<p>F 0606</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resulting in discrepancy of unaccounted 3.5 ML of Morphine Sulfate and missing Neurontin on 12/26/23 at 3:40 PM. Nurse unable to produce missing medication or account for missing pill during hand off cart and narcotic count.</p> <p>Employee response: I have no excuse I don't know what happened.</p> <p>Facility requested an extension for the five-day follow-up pending on police report on 12/28/23.</p> <p>Final report was faxed 01/04/24 at 12:23 PM.</p> <p>Conclusion: Employee terminated, unable to prove or disprove allegation.</p> <p>On 04/24/24 at 10:22 AM the Administrator was asked if the above events were reported to the nursing board. The initial answer was yes. The administrator was asked for the reportable number and could not provide one.</p> <p>On 04/24/24 at 11:40 AM a phone call was made to the [NAME] Virginia board of Nursing (LPN). It was reported that no complaint had been made on LPN #115.</p> <p>On 04/24/24 at 12:12 PM, the administration was informed that no complaints had been filed for LPN #115. And no further information was provided.</p> <p>b) LPN #113</p> <p>Resident #31</p> <p>It was discovered that on 03/31/24 Resident #31 went without having an acu-check and insulin from 6 AM to 7 PM. This was reported by Resident #31 and investigated by the facility and found to be true.</p> <p>LPN #113 was the assigned nurse for Resident #31.</p> <p>2) Resident #71</p> <p>A review of the Nursing Home initial reporting allegation form found LPN # 113 documented an antibiotic was given to Resident #71 on 03/30/24. However, the antibiotic was found in the medication cart on 04/01/24 at 8:45 AM by LPN #24. This was also witnessed by Registered Nurse # 19.</p> <p>3) Resident # 20</p> <p>A review of the Nursing Home initial reporting allegation form found LPN # 113 documented a controlled medication Neurontin was given to Resident #20 on 03/30/24 at 1:00 PM. However, the medication was found in the medication cart on 04/01/24 at 8:45 AM by LPN #24. This was also witnessed by Registered Nurse # 19.</p> <p>4) Resident # 45</p> <p>(continued on next page)</p>		

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<p>F 0606</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Nursing Home initial reporting allegation form found LPN # 113 documented a controlled medication Ativan was given to Resident #45 on 03/30/24. However, the medication was found in the medication cart on 04/01/24 at 8:45 AM by LPN #24. This was also witnessed by Registered Nurse # 19.</p> <p>The five-day follow-up resulted in LPN #113 being terminated on 04/05/24.</p> <p>On 04/24/24 at 10:22 AM the Administrator was asked if the above events were reported to the nursing board. The initial answer was yes. The administrator was asked for the reportable number and could not provide one.</p> <p>On 04/24/24 at 11:40 AM a phone call was made to the [NAME] Virginia board of Nursing (LPN). It was reported that no complaint has been made on LPN #113.</p> <p>On 04/24/24 at 12:12 PM the administration was informed that no complaints had been filed for LPN #113. No further information was provided.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>45174</p> <p>Based on record review and staff interview, the facility failed to ensure an allegation of verbal abuse was reported to all the proper State Authorities. This was true for one (1) resident reviewed in the care area of verbal abuse during a complaint survey. Resident identifier: #10. Facility census: 99.</p> <p>Findings included:</p> <p>a) Policy Review</p> <p>A review of a facility policy titled Abuse Prevention Program with a revision date of 12/16 read as follows:</p> <p>2. Verbal abuse may be considered to be type of mental abuse. Verbal abuse includes the use of verbal, written or gestured communication, or sounds, to residents within hearing distance, regardless of age, ability to comprehend, or disability.</p> <p>3. Examples of mental and verbal abuse include, but are not limited to:</p> <p>a.harassing a resident</p> <p>b. mocking, insulting, ridiculing</p> <p>c. yelling or hovering over a resident, with the intent to intimidate;</p> <p>d. threatening residents, including but not limited to, depriving a resident of care or withholding a resident from contact with family and friends; and</p> <p>e. isolating a resident from social interaction or activities.</p> <p>b) Resident #10</p> <p>A review of the facility grievance and concerns records on 04/24/24 at 9:15 AM revealed a Grievance/Concern form dated 03/26/24.</p> <p>The form contained the following information typed as written:</p> <p>Individual initiating concern: Family/Representative</p> <p>Print name of person with concern and resident concern is regarding Name (daughter) no resident name was provided.</p> <p>Describe concern in detail using factual support: (typed as written)</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Nurse or aid argumentative with patient feels like this evening staff wont assist with keeping mother calm. Daughter heard a discussion while on the phone with mother.</p> <p>During an interview, on 04/24/24 at 9:28 AM the Director of Nursing (DON), The Administrator and Assistant Director of Nursing (ADON) were all present.</p> <p>The DON stated, This was (Resident #10's name) I remember this. The Administrator stated, We spoke with the staff, and we felt it was more of a customer service issue of that staff tone of voice.</p> <p>The ADON stated, I spoke to the family in length about this issue and she was fine with the issue. Yes, I documented that I spoke to her and what was said.</p> <p>During an interview, on 04/24/24 at 10:39 AM, the DON stated there was no documentation that the ADON spoke to the family representative. The DON acknowledged a reportable form, and an investigation should have been completed and reported to the appropriate agencies. The DON said, I will begin the process at this time.</p>		

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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor each resident's preferences, choices, values and beliefs.</p> <p>39571</p> <p>Based on record review and staff interview the facility failed to ensure all residents attain or maintain the highest practicable physical, mental, and psychosocial well-being. This failed practice was true for seven (7) out of seven (7) reviewed for sexual behavior which were ordered 15-minute monitoring checks without a duration or time frame to discontinue the checks. This was depriving the residents of sense of wellbeing for quality of life. Resident identifiers: #57, #2, #95, #99, #62, #37, and #60. Facility censuses 99.</p> <p>Findings include:</p> <p>a) Resident #57</p> <p>A review of facility records found Resident # 57 was placed on 15-minute monitor check on 02/14/24 at 4:05 PM after this Resident was found in bed with another incapacitated resident without any pants on. Both residents reside in the memory unit.</p> <p>An interview with the Director of Nursing (DON) on 04/23/24 at 5:10 PM. The DON was asked how long the 15-minute monitoring checks were going to continue. The DON responded by saying she and the Administrator were talking about that and she believes they will do them for 90 days. The DON agreed there was no order in place to discontinue these checks. A facility policy for monitoring residents every 15-minutes was requested, however, no policy was provided by the close of this survey.</p> <p>b) Resident #2</p> <p>A review of facility records found Resident #2 was placed on 15-minute checks on 02/13/24 at 1:04 AM after having an altercation with the roommate and stating she was leaving.</p> <p>On 04/23/24 at 5:10 PM, an interview with the DON confirmed there was an order to start 15-minute monitoring checks on 02/13/24 at 1:04 AM. The DON also confirmed the 15-minute checks have continued since then with no order or plan in place to end the 15-minute checks as of today.</p> <p>c) Resident #95</p> <p>A review of the facility records revealed Resident # 95 was placed on 15-minute monitoring checks on 03/30/24 at 9:00 PM. After the nursing staff witnessed him kiss another Resident on the mouth at the nurse's station. Resident # 95 has capacity, and it was reported that the resident he kissed did not object to being kissed.</p> <p>On 04/24/24 at 2:00 PM an interview with the DON and Administrator found that the 15-minutes checks (monitoring residents' movements) are presently still ongoing. The DON was asked how long Resident #95 was going to remain on the 15-minute checks. The DON stated that she and the Administrator were discussing it today and she decided to continue them for 90 days.</p> <p>d) Resident # 99</p> <p>(continued on next page)</p>		

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<p>F 0675</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>While reviewing the facility documents it found Resident # 99 was placed on 15-minute monitoring checks on 03/30/24 at 9:00 PM, for being kissed by another resident, whom she is very close to.</p> <p>On 04/24/24 at 2:00 PM an interview with the DON and Administrator found that the 15-minutes checks (monitoring residents' movements) are presently still ongoing. The DON was asked how long Resident #99 was going to remain on the 15-minute checks. The DON stated that she and the Administrator were discussing it today and she decided to continue them for 90 days.</p> <p>e) Resident #62</p> <p>A review of facility records found Resident # 62 was placed on 15-minute monitor checks on 03/30/24 at 10:49 AM after this resident was found touching and kissing another resident. Both residents reside in the memory unit.</p> <p>An interview with the DON on 04/23/24 at 5:10 PM. The DON was asked how long this 15-minute monitoring checks were going to continue. The DON responded by saying she and the Administrator were talking about that and she believes they will do them for 90 days. The DON agreed there was no order in place to discontinue these checks. A facility policy for monitoring residents every 15-minutes was requested, no policy was provided by the close of survey.</p> <p>f) Resident # 37</p> <p>A review of facility records found Resident # 37 was placed on 15-minute monitor checks on 03/30/24 at 1:47 PM after this resident was found kissing and being touched by another resident. Both residents resided in the memory unit.</p> <p>An interview with the DON on 04/23/24 at 5:10 PM. The DON was asked how long these 15-minute monitoring checks were going to continue. The DON responded by saying she and the Administrator were talking about that and she believed they would do them for 90 days. The DON agreed there was no order in place to discontinue these checks. A facility policy for monitoring residents every 15-minutes was requested, no policy was provided by the close of survey.</p> <p>g) Resident #60</p> <p>A review of facility records found Resident #60 was placed on 15-minute monitor checks on 01/20/24 at 7:00 AM after this resident made an inappropriate sexual comment to another resident in the facility.</p> <p>An interview with the DON on 04/23/24 at 5:10 PM. The DON was asked how long this 15-minute monitoring checks were going to continue. The DON responded by saying she and the Administrator were talking about that and she believed they would do them for 90 days. The DON agreed there was no order in place to discontinue these checks. A facility policy for monitoring residents every 15-minutes was requested, no policy was provided by the close of survey.</p> <p>50551</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>39571</p> <p>Based on medical record review, and staff interview the facility failed to give medication as ordered by the physician, failed to complete 15-minute monitoring of a resident, failed to complete neuro checks after an unwitnessed fall. These failed practices were true for six (6) out of six (6) residents reviewed for late medications, and seven (7) out of seven (7) residents reviewed for 15-minute monitoring, and one (1) out of one (1) resident reviewed for neuro checks. Resident identifiers: #33, #62, #31, #7, #43, #20, #37, #60, and #90. Facility Census:</p> <p>Findings included:</p> <p>a) Resident #33</p> <p>A review of the facility records titled; Medication Audit Report revealed the following order:</p> <p>Eliquis (an anticoagulant to prevent blood clots) One (1) tablet twice a day was ordered by the facility attending physician.</p> <p>On 03/15/24 this medication was scheduled to be administered at 9:00 PM and was not given until 11:06 PM by Licensed Practical Nurse (LPN) #1. There were not any nursing notes to indicate why or that the attending physician was notified.</p> <p>Resident #33 also had an order for Norvasc (used to treat high blood pressure) One (1) tablet twice a day was ordered by the attending physician.</p> <p>On 03/15/24 this medication was scheduled to be administered at 9:00 PM and was not given until 11:06 PM by Licensed Practical Nurse (LPN) #1. There were not any nursing notes to indicate why or that the attending physician was notified.</p> <p>Resident #33 also had an order for Lantus (used to control blood glucose levels) injected 13 units at bedtime was ordered by the facility attending physician.</p> <p>On 03/23/24 this medication was scheduled to be administered at 9:00 PM and was not given until 11:27 PM by LPN #1. This was 2 hours and 27 minutes late.</p> <p>Norvasc and Eliquis were scheduled to be administered at 9:00 PM on 03/23/24. These medications were not given until 11:27 PM by LPN #1.</p> <p>Novolog insulin (used to control glucose levels for type two (2) diabetes) was scheduled to be administered at 9:00 PM on 03/23/24 and was not given until 11:27 PM by LPN #1.</p> <p>Bactrim DS (this is an antibiotic used for an infection) was ordered to be given every 12 hours. This medication was scheduled for 9:00 PM and was not given until 11:27 PM on 03/23/24 by LPN #1.</p> <p>On 03/29/24 LPN #1 should have administered Lantus, Novolog, Eliquis, and Norvasc at 9:00 PM. These medications were not given until 11:59 PM. That was nearly three (3) hours late.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/10/24 LPN #4 should have administered Lantus, Novolog, Eliquis, Norvasc at 9:00 PM. These medications were documented as given at 11:32 PM.</p> <p>On 04/20/24 LPN #1 should have administered Lantus, Novolog, Eliquis, Norvasc at 9:00 PM. These medications were documented as given at 10:46 PM.</p> <p>On 04/24/24 at 9:20 AM the Director of Nursing and the Assistant Director of Nursing verified and agreed the above medications were given more than an hour late and no nursing notes found the explain why.</p> <p>b) Resident #31</p> <p>A review of the facility document called the Medication Admin Audit Report found Resident #31 received the following medication more than an hour after it was scheduled to be given.</p> <p>On 03/14/24 Novolog insulin flex-pen was scheduled for 8:00 PM and to be given before meals and at bedtime. This medication was given at 11:25 PM by LPN # 71.</p> <p>Additional medications which were administered late were,</p> <p>--Acidophilus (given for digestive health) and is scheduled three (3) times a day.</p> <p>--Albuterol Inhalation was to be given four (4) times a day for Chronic Obstructive Pulmonary Disease (COPD),</p> <p>--Fluticasone-Salmeterol inhaler two (2) times a day for Shortness of breath,</p> <p>--Eliquis two (2) times a day for ischemic attack,</p> <p>--Metoprolol to be given two (2) times a day for hypertension.</p> <p>The above medication was scheduled for 9:00 PM and was given at 10:31 PM.</p> <p>-- Insulin Detemir Pen-injector two (2) times a day for Diabetes.</p> <p>The above medication was scheduled for 9:00 PM and was given at 11:25 PM.</p> <p>On 03/15/24 Novolog insulin flex-pen was scheduled for 8:00 PM and to be given before meals and at bedtime. This medication was given at 10:56 PM by LPN # 71.</p> <p>Additional medications which were administered late were,</p> <p>--Acidophilus (given for digestive health) and is scheduled three (3) times a day.</p> <p>--Albuterol Inhalation was to be given four (4) times a day for Chronic Obstructive Pulmonary Disease (COPD),</p> <p>--Fluticasone-Salmeterol inhaler two (2) times a day for Shortness of breath,</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>--Eliquis two (2) times a day for ischemic attack,</p> <p>--Metoprolol to be given two (2) times a day for hypertension.</p> <p>The above medication was scheduled for 9:00 PM and was given at 10:47 PM.</p> <p>--Insulin Detemir Pen-injector two (2) times a day for Diabetes.</p> <p>The above medication was scheduled for 9:00 PM and given at 10:56 PM.</p> <p>On 03/16/24 Novolog insulin flex-pen was scheduled for 11:00 AM and to be given before meals and at bedtime. This medication was given at 12:51 PM by LPN # 113.</p> <p>Additional medication which were administered late were,</p> <p>--Acidophilus (given for digestive health) and is scheduled three (3) times a day. Albuterol Inhalation was to be given four (4) times a day for Chronic Obstructive Pulmonary Disease (COPD), were scheduled of 11:00 AM was not given until 12:51 PM.</p> <p>On 03/18/24 Novolog insulin flex-pen was scheduled for 8:00 PM and to be given before meals and at bedtime. This medication was given at 9:55 PM by LPN # 71.</p> <p>On 03/19/24 Novolog insulin flex-pen was scheduled for 8:00 PM and to be given before meals and at bedtime. This medication was given at 11:38 PM by LPN # 71.</p> <p>Additional medications which were administered late were,</p> <p>--Acidophilus (given for digestive health) and is scheduled three (3) times a day.</p> <p>--Albuterol Inhalation was to be given four (4) times a day for Chronic Obstructive Pulmonary Disease (COPD),</p> <p>--Fluticasone-Salmeterol inhaler two (2) times a day for Shortness of breath,</p> <p>--Eliquis two (2) times a day for ischemic attack,</p> <p>--Metoprolol to be given two (2) times a day for hypertension.</p> <p>--Insulin Detemir Pen-injector two (2) times a day for Diabetes.</p> <p>The above medication was scheduled for 9:00 PM and given at 11:38 PM.</p> <p>On 03/24/24 Novolog insulin flex-pen was scheduled for 8:00 PM and to be given before meals and at bedtime. This medication was given at 10:03 PM by LPN # 71.</p> <p>On 03/25/24 LPN #113 administered the following medication more than an hour late.</p> <p>Novolog insulin flex-pen was scheduled for 4:00 PM before meals and was given at 7:16 PM.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Albuterol Inhalation was to be given four (4) times a day for Chronic Obstructive Pulmonary Disease (COPD), This medication was scheduled for 5:00 PM and was given at 7:16 PM.</p> <p>On 03/28/24 Novolog insulin flex-pen was scheduled for 8:00 PM and to be given before meals and at bedtime. This medication was given at 10:34 PM by LPN # 71.</p> <p>Additional medications which were administered late were,</p> <p>--Acidophilus (given for digestive health) and is scheduled three (3) times a day.</p> <p>--Albuterol Inhalation was to be given four (4) times a day for Chronic Obstructive Pulmonary Disease (COPD),</p> <p>--Fluticasone-Salmeterol inhaler two (2) times a day for Shortness of breath,</p> <p>--Eliquis two (2) times a day for ischemic attack,</p> <p>--Metoprolol to be given two (2) times a day for hypertension.</p> <p>The above medication was scheduled for 9:00 PM and given at 10:31 PM</p> <p>--Insulin Detemir Pen-injector two (2) times a day for Diabetes.</p> <p>The above medication were scheduled for 9:00 PM and given at 11:25 PM.</p> <p>On 03/30/24 Novolog insulin flex-pen was scheduled for 8:00 PM and to be given before meals and at bedtime. This medication was given at 9:50 PM by LPN # 24.</p> <p>On 04/01/24 Novolog insulin flex-pen was scheduled for 8:00 PM and to be given before meals and at bedtime. This medication was given at 9:40 PM by LPN # 71.</p> <p>On 04/02/24 Novolog insulin flex-pen was scheduled for 8:00 PM and to be given before meals and at bedtime. This medication was given at 10:41 PM by LPN # 71.</p> <p>Additional medications which were administered late were,</p> <p>--Acidophilus (given for digestive health) and is scheduled three (3) times a day.</p> <p>--Albuterol Inhalation was to be given four (4) times a day for Chronic Obstructive Pulmonary Disease (COPD),</p> <p>--Fluticasone-Salmeterol inhaler two (2) times a day for Shortness of breath,</p> <p>--Eliquis two (2) times a day for ischemic attack,</p> <p>--Metoprolol to be given two (2) times a day for hypertension.</p> <p>The above medication were scheduled for 9:00 PM and was given at 10:30 PM.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Insulin Detemir Pen-injector two (2) times a day for Diabetes.</p> <p>The above medication was scheduled for 9:00 PM and was given at 10:41 PM.</p> <p>On 04/09/24 Novolog insulin flex-pen was scheduled for 11:00 AM and to be given before meals and at bedtime. This medication was given at 1:01 PM by LPN # 2.</p> <p>Additional medications which were administered late were,</p> <p>--Acidophilus (given for digestive health) and is scheduled three (3) times a day.</p> <p>--Albuterol Inhalation was to be given four (4) times a day for Chronic Obstructive Pulmonary Disease (COPD), were scheduled of 11:00 AM was not given until 1:01 PM.</p> <p>On 04/1424 LPN # 2 administered the following medication more than an hour late:</p> <p>--Acidophilus (given for digestive health) and is scheduled three (3) times a day. Albuterol Inhalation was to be given four (4) times a day for Chronic Obstructive Pulmonary Disease (COPD), were scheduled of 11:00 AM was not given until 1:34 PM.</p> <p>On 04/21/24 Novolog insulin flex-pen was scheduled for 8:00 PM and to be given before meals and at bedtime. This medication was given at 10:10 PM by LPN # 71.</p> <p>The above medication was scheduled for 9:00 PM and given at 11:25 PM.</p> <p>On 04/24/24 at 9:20 AM the Director of Nursing and the Assistant Director of Nursing verified and agreed the above medications were given more than an hour late and no nursing notes found the explain why.</p> <p>c) Resident #7</p> <p>During a review of the facility form title, Medication Admin Audit Report, the following medications were found to be administered past the one (1) hour of standard of care practice:</p> <p>NovoLOG FlexPen Subcutaneous Solution Pen-injector (insulin used to control type two (2) diabetes), inject 15 units subcutaneously before meals. This medication was due on 03/16/24 at 11:00 AM and was given at 12:55 PM by Licensed Practical Nurse (LPN) #113.</p> <p>Symbicort Inhalation Aerosol (used for chronic obstructive pulmonary disease, unspecified) 80-4.5 MCG/ACT, give two (2) puffs inhale orally two times a day. The medication was due on 03/21/24 at 9:00 AM and was not given until 10:34 AM by Licensed Practical Nurse (LPN) #113.</p> <p>Lactulose Oral Solution (used for elevated ammonia level related to alcohol cirrhosis of liver without ascites, give 30 ml by mouth three (3) times a day. The medication was due on 03/21/24 at 9:00 AM and was given at 10:34 AM by LPN #113.</p> <p>Lactulose Oral Solution, give 30 ml by mouth three (3) times a day. Was due on 03/21/24 at 3:00 PM and was given at 4:57 PM by LPN #113.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>NovoLOG FlexPen Subcutaneous Solution Pen-injector (insulin used to control type two (2) diabetes), inject 15 units subcutaneously before meals. This medication was due on 03/25/24 at 4:00 PM and was given at 7:18 PM by Licensed Practical Nurse (LPN) #113.</p> <p>Lactulose Oral Solution (used for elevated ammonia level related to alcohol cirrhosis of liver without ascites), give 30 ml by mouth three (3) times a day. The medication was due on 03/29/24 at 3:00 PM and was given at 4:49 PM by LPN #2.</p> <p>NovoLOG FlexPen Subcutaneous Solution Pen-injector (insulin used to control type two (2) diabetes), inject seven (7) units subcutaneously before meals. This medication was due on 03/30/24 at 11:00 AM and was given at 1:39 PM by Licensed Practical Nurse (LPN) #113.</p> <p>NovoLOG FlexPen Subcutaneous Solution Pen-injector (insulin used to control type 2 diabetes), inject seven (7) units subcutaneously before meals. This medication was due on 03/31/24 at 11:00 AM and was given at 12:42 PM by Licensed Practical Nurse (LPN) #113.</p> <p>Lactulose Oral Solution (used for elevated ammonia level related to alcohol cirrhosis of liver without ascites), give 30 ml by mouth three (3) times a day. The medication was due on 04/08/24 at 3:00 PM and was given at 4:31 PM by LPN #2.</p> <p>NovoLOG FlexPen Subcutaneous Solution Pen-injector (insulin used to control type two (2) diabetes), inject seven (7) units subcutaneously before meals. This medication was due on 04/10/24 at 4:00 PM and was given at 5:36 PM by Licensed Practical Nurse (LPN) #2.</p> <p>Lactulose Oral Solution (used for elevated ammonia level related to alcohol cirrhosis of liver without ascites), give 30 ml by mouth three (3) times a day. The medication was due on 04/13/24 at 3:00 PM and was given at 4:47 PM by LPN #2.</p> <p>Lactulose Oral Solution (used for elevated ammonia level related to alcohol cirrhosis of liver without ascites), give 30 ml by mouth three (3) times a day. The medication was due on 04/18/24 at 3:00 PM and was given at 5:00 PM by LPN #2.</p> <p>Lactulose Oral Solution (used for elevated ammonia level related to alcohol cirrhosis of liver without ascites), give 30 ml by mouth three (3) times a day. The medication was due on 04/19/24 at 3:00 PM and was given at 5:12 PM by LPN #2.</p> <p>On 04/24/24 at 9:20 AM the Director of Nursing and the Assistant Director of Nursing verified and agreed the above medications were given more than an hour late and no nursing notes were found to explain why.</p> <p>d) Resident #43</p> <p>During a review of the facility form titled, Medication Admin Audit Report, the following medications were administered past the one (1) hour of standard of care practice:</p> <p>Fluticasone-Salmeterol Inhalation Aerosol Powder Breath Activated 100-50 MCG/ACT (for acute chronic respiratory failure), give one (1) puff inhale orally two times a day. The medication was due on 03/15/24 at 9:00 PM and was given at 10:46 PM by LPN #71.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Glasgow Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Melrose Drive, Box 350 Glasgow, WV 25086	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>LevETIRAcetam Oral Tablet 500 mg, give one (1) tablet by mouth two times per day for seizures. The medication was due on 03/15/24 at 9:00 PM and was given at 10:46 PM by LPN #71.</p> <p>Ativan Oral Tablet 0.5 mg, give one (1) tablet by mouth every 6 (six) hours for anxiety, agitation. The medication was due on 04/13/24 at 12:00 PM and was given at 1:40 PM by LPN #2.</p> <p>On 04/24/24 at 9:20 AM Director of Nursing and the Assistant Director of Nursing verified and agreed the above medications were given more than an hour late and no nursing notes found the explain why.</p> <p>e) Resident #20</p> <p>During a review of the facility form titled, Medication Admin Audit Report, the following medications were administered past the one (1) hour of standard of care practice:</p> <p>Gabapentin Oral Tablet 800mg (for diabetes mellitus neuropathy), give one (1) tablet by mouth three (3) times a day. The medication was due on 03/21/24 at 1:00 PM and was given at 2:45 PM by LPN # 113.</p> <p>A finger stick (to monitor blood glucose), take before meals and at bedtime was due on 03/21/24 at 8:00 PM and was taken at 9:59 PM by LPN #24.</p> <p>Nateglinide Oral Tablet 120 mg, give one (1) tablet by mouth before meals for diabetes mellitus. The medication was due on 03/25/24 at 4:00 PM and was given at 7:16 PM by LPN #113.</p> <p>A finger stick (to monitor blood glucose), take before meals and at bedtime was due on 03/25/24 at 4:00 PM and was taken at 7:19 PM by LPN #113.</p> <p>Gabapentin Oral Tablet 800mg (for diabetes mellitus neuropathy), give one (1) tablet by mouth three (3) times a day. The medication was due on 03/26/24 at 1:00 PM and was given at 2:48 PM by RN #9.</p> <p>A finger stick (to monitor blood glucose), take before meals and at bedtime was due on 03/30/24 at 8:00 PM and was taken at 10:23 PM by LPN #24.</p> <p>A finger stick (to monitor blood glucose), take before meals and at bedtime was due on 03/31/24 at 11:00 AM and was taken at 12:38 PM by LPN #113.</p> <p>Ranolazine ER Oral Tablet Extended Release 12-hour 500mg, give one (1) tablet by mouth two (2) times a day for chest pain. The medication was due on 04/02/24 at 9:00 PM and was given at 10:32 PM by LPN #71.</p> <p>Gabapentin Oral Tablet 800mg (for diabetes mellitus neuropathy), give one (1) tablet by mouth three (3) times a day. The medication was due on 04/03/24 at 1:00 PM and was given at 5:04 PM by LPN #2.</p> <p>A finger stick (to monitor blood glucose), take before meals and at bedtime was due on 03/31/24 at 8: 00 PM and was taken at 9:42 PM by ADON.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Glasgow Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Melrose Drive, Box 350 Glasgow, WV 25086	

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 04/24/24 at 9:20 AM Director of Nursing and the Assistant Director of Nursing verified and agreed the above medications were given more than an hour late and no nursing notes found the explain why.</p> <p>f) Resident #62</p> <p>Review of 15-minute monitoring sheets with the DON on 04/23/24 at 5:14 PM, confirmed many pages were missing location and/or nurse signature as well as multiple blank spaces. The following sheets had blank spaces/missing data for the following times:</p> <p>04/02/24 no data from 7:15 PM to 11:45 PM.</p> <p>04/04/24 no data from 12:00 AM to 1:45 PM.</p> <p>04/05/24 no data from 12:00 AM to 6:30 AM.</p> <p>04/12/24 no data from 6:30 AM to 11:45 PM.</p> <p>04/23/24 no data from 2:00 PM to 11:45 PM.</p> <p>g) Resident # 37</p> <p>Review of 15 minute monitoring sheets with DON on 04/23/24 at 5:14 PM, DON agreed that many pages were missing location and/or nurse signature as well as multiple blank spaces. The following sheets had blank spaces/missing data for the following times:</p> <p>04/13/24 no data at 6:45 AM</p> <p>04/14/24 no data at 6:45 AM.</p> <p>04/15/24 no data at 7:00 AM</p> <p>h) Resident #60</p> <p>Review of 15-minute monitoring sheets with DON on 04/23/24 at 5:14 PM, DON agreed that many pages were missing location and/or nurse signature as well as multiple blank spaces. The following sheets had blank spaces/missing data for the following times:</p> <p>03/08/24 no data from 2:45 PM to 6:30 PM.</p> <p>03/10/24 no data from 7:15 PM to 10:30 PM.</p> <p>04/18/24 no data at 10:15 AM</p> <p>i) Resident #90</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a medical record review on 04/24/24 at 1:30 PM Resident #90's medical record revealed a physician order dated 03/19/24 at 9:34 AM for Neuro checks every shift for post fall 03/19 for three days.</p> <p>Further record review revealed a neuro check record was void the following documentation on 03/19/24:</p> <p>-8:00AM</p> <p>-8:15 AM</p> <p>-8:30 AM</p> <p>-8:45 AM</p> <p>-9:45 AM</p> <p>-10:45 AM</p> <p>-11:45 AM</p> <p>-12:45 PM</p> <p>-4:45 PM</p> <p>During an interview on 04/24/24 at 11:19 AM the DON acknowledged the neuro checks were not completed according to the physician orders.</p> <p>By the end of the survey no facility neuro check policy was provided.</p> <p>45174</p> <p>.</p> <p>50551</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>39571</p> <p>Based on observation and staff interview the facility failed to ensure the resident environment over which it had control and remained as free of accident hazards as was possible. This was a random opportunity for discovery and had the potential to affect more than a limited number of residents who reside at the facility. Facility census: 99.</p> <p>Findings included:</p> <p>a) Medication room</p> <p>On 04/24/24 at 1:04 PM the medication room door was observed propped open and unattended. This was witnessed by Licensed Practical Nurse (LPN) #56. LPN #56 stated the Pharmacy tech was the person that did it.</p> <p>On 04/24/24 at 1:09 PM the Pharmacy Tech returned to the medication room from a room beside the Medication room and closed the door.</p> <p>b) Electrical box</p> <p>On 04/24/24 at 1:10 PM at the west nurse's station there was an electrical box on the wall that had a padlock on the door, but the padlock was unlocked. This was pointed out to LPN #56. LPN #56 locked the padlock.</p> <p>The above observations were reported to the Administrator at 1:15 PM. No comments were made.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>39571</p> <p>Based on facility documents and staff interviews the facility failed to meet the requirements of the staff posting by failing to reflect the actual number of staff who worked and the actual number of hours they worked. This failed practice had the potential to affect a limited number of residents. Facility census: 99.</p> <p>Findings included:</p> <p>a) Staff Posting</p> <p>On 04/22/24 at 3:23 PM, the Administrator provided the staff postings for the last two (2) weeks. A review of these documents revealed the posting sheets were not a working sheet to reflect a call-out. The Administrator was asked if the facility had any callouts in that time frame.</p> <p>After a review of the direct care staff time punch card for the last two (2) weeks it was found the facility had 13 callouts in that time frame.</p> <p>On 04/24/24 at 9:10 AM the Administrator agreed the staff postings had not been corrected and/or updated the reflection of the actual number of staff that worked.</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>39571</p> <p>Based on medical record review and staff interview the facility failed to ensure all handwritten skin assessments were clear and accurate and contained enough information to accurately identify the resident. This failed practice had the potential to effect more than a limited number of residents. Facility census: 99.</p> <p>Findings include:</p> <p>a) Skin assessment</p> <p>While reviewing the medical records of residents that have had skin assessments because of a sexual behavior allegation of another resident. 12 forms were found where the name of the resident was unidentifiable or was missing altogether.</p> <p>On 04/23/24 at 1:10 PM the Director of Nursing (DON) was shown the skin assessment forms and agreed that six (6) had unidentifiable names and six (6) had no names. It was also pointed out that the forms did not have a date or shift on the form. The DON confirmed all 12 pages had the signature of the Assistant Director of Nursing.</p>

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>39571</p> <p>Based on observation and staff interview the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents. This was a random opportunity for discovery and had the potential to affect a limited number of residents who reside at the facility. Facility census: 99.</p> <p>Findings included:</p> <p>a) Low temperature</p> <p>On 04/24/24 at 12:45 PM an observation of the residents sitting at the nurses with a blanket on. The area felt very cool. Called for Maintenance Assistant #6 to please check the temperature at chair level with an ambient thermometer.</p> <p>On 04/24/24 at 12:49 PM Maintenance Assistant #6 had an ambient thermometer and the temperature at chair level was 61 degrees and the wall thermometer was set on 69. Maintenance Assistant #6 changed it to 74 degrees. Maintenance Assistant #6 went on to say he had to change the thermostat back up all the time.</p>