STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515118	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glasgow Hills of Journey	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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review, resident interview, and staff interview, the facility failed to make prompt efforts to resolve a resident grievance. The facility failed to follow through on purchasing new pajamas for a resident after they were lost in the facility. This was a random opportunity for discovery during a complaint investigation. Census: 105. Resident identifier: #40.Findings included:a) Resident #40A review of the the Resident and Family Grievances policy revealed the following, The facility will make prompt efforts to resolve grievances.A grievance filed by Resident #40 on 02/05/26 stated she was missing a pajama set. The official follow-up written on the grievance form stated the pajamas were being replaced with a date resolved written as 02/10/26.During an interview on 05/11/26, Resident #40 stated she was missing a pajama set and had filed a grievance, but the pajamas had not been replaced. During an interview, on 05/11/26 at 1:10 PM, the Social Worker confirmed the pajamas had not been replaced.

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
	515118	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glasgow Hills of Journey	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm 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. Based on record review and staff interview, the facility failed to develop a care plan for Resident #40 based on accurate diagnoses. This was a random opportunity for discovery during a complaint investigation. Resident identifier: #40. Facility census: 105.Findings included:During a review of Resident #40's electronic medical record, the following discrepancy was found:-A review Resident #40's care plan included a focus as follows: The resident has hemiplegia/hemiparesis. Date initiated: 04/07/26.-A review of the diagnosis list for Resident #40 confirmed there was no diagnosis for hemiplegia or hemiparesis.-A review of the Minimum Data Set (MDS) confirmed there were no impairments on either side.During an interview on 05/12/26 at 10:40AM, the Director of Nursing confirmed that the diagnosis on the care plan was incorrect, and Resident #40 did not have hemiplegia/hemiparesis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	515118	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glasgow Hills of Journey	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)
F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to comply with all applicable state laws, regulations, and codes. The facility's Infections Medical Waste Program permit was expired. This was a random opportunity for discovery. Facility census: 105.Findings included:The facility's Bureau for Public Health, Office of Environmental Health Services, Infectious Medical Waste Program permit, which was posted on the wall in the facility, was issued [DATE] and expired [DATE]. On [DATE] at 10:30 AM, the administrator confirmed the Infectious Medical Waste Program permit expired. She stated she had submitted the invoice to corporate for payment, but it had not yet been paid. On [DATE] at 11:33 AM, the Administrator stated she had just paid the invoice to renew the facility's Infectious Medical Waste Program permit. She provided the receipt to show the invoice had been paid.