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	06/30/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff interview and record review the facility failed to ensure Resident #85 received the assistance he needed with eating to enable him to maintain his dignity. This was true for one (1) of five (5) residents reviewed for the care area of Activities of Daily Living (ADL) during the long-term care survey process. Resident Identifier: #85. Facility Census:101. Findings Include: a) Resident #85 An observation of the noontime meal on 06/24/25 found Resident #85 was feeding himself with his fingers. He was eating Turkey Tex Mex which contained rice and bake beans. The resident was dropping food on his clothes. An additional observation of the noon time meal on 06/25/25 found the resident again feeding himself with his fingers. He ate a piece of pineapple upside down cake with his hands. He also had on his plate mashed potatoes, chopped broccoli and ground meatballs with gravy. He attempted to eat some mashed potatoes but had difficulty. An observation of his dining area found there were cake crumbs and bits of food scattered around the floor. He then left the dining room. During the observations no staff member was observed telling the resident to use his utensils. An interview with Nurse Aide (NA) #13 and NA #78 at 12:00 PM on 06/25/25 confirmed the resident always uses his hands to feed himself. They indicated the resident can use utensils, but he requires constant supervision and queuing to use the utensils. NA # 13, stated It has to be one on one. They both agreed that once he gets started using his utensils he does very well. An interview with the speech therapist at 1:45 PM on 06/25/25 confirmed the resident does very well when you get him started with his utensils. She indicated once you show him the utensils and get him started, he will finish eating and will do very well. A review of Resident #85's care plan found the following related to eating: Eating Assist: The res requires Set-Up, w/ eating. This was added to the care on 05/11/24 and was the active intervention at the time of this review. This confirmed with the Director of Nursing (DON) on the afternoon of 06/25/25.

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	06/30/2025

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, the facility failed to provide evidence the required Notification of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form were issued and signed in a timely fashion for one (1) of three (3) residents reviewed for beneficiary protection notification. This failure had the potential to place the resident's legal representative at risk of not being informed of the resident's rights prior to the end of Medicare Part A covered services. Resident identifier: #102. Facility census: 101. Findings included: a) Beneficiary Notice Review A record review, completed on 06/25/25 at 12:26 PM, revealed: -Resident #102 was admitted to the facility on [DATE] -Resident #102's last covered day of Part A Service was on 05/30/25 -The NOMNC and SNF ABN forms were issued on 05/28/25 and signed by Resident #102 - The End of PPS (Prospective Payment System) Part A Minimum Dated Set, dated 05/30/25, reflected a Brief Interview for Mental Status (BIMS) score of 06. A BIMS score of 06 is indicative of severe cognitive impairment. -A physician determination of capacity, dated 04/25/25, reflected resident did not have capacity. -The emergency contact number for Resident #102 was listed as a Adult Protective Services (APS) Worker and resident's health care proxy. During an interview on 06/25/25 at 1:06 PM, the facility's Social Worker reported she would defer to the legal representative to sign for any resident who was determined to not have capacity. During an interview on 06/25/25 at 1:53 PM, the Administrator stated that the NOMNC form has been considered a financial document from the business office perspective. The Administrator noted it had been an oversight that the correct individual had not signed the form.

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	06/30/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** FACILITY Environment Based on observation and staff interview the facility failed to ensure the resident environment was clean and homelike. This was a random opportunity for discovery and as true for the bathroom shared between room [ROOM NUMBER] and 311. Facility Census: 101. Findings Include: On 06/30/25 at 11:45 am a tour with the Dementia Unit Director found the toilet seat attached to the toilet shared between room [ROOM NUMBER] and 311 was in poor repair. It appeared to be dirty at first glance, but the director indicated that the plastic coating was off and why it was discolored she stated, I have told maintenance about it. Also, in the same bathroom the baseboard trim was missing along the wall toward room [ROOM NUMBER].

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	06/30/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, record review, and staff interview, the facility failed to ensure complete and accurate Minimum Data Set (MDS) assessments for two (2) of 30 residents reviewed in the long-term care survey sample. Resident Identifiers: #59 and #88. Facility census: 101. Findings included: a) Resident #59 On 06/25/25 at 3:08 PM, Resident #59 was interviewed. She was noted to have a tracheostomy tube with a speaking valve. Resident #59 stated she had the tracheostomy placed at the hospital before she was admitted to the facility. Review of Resident #59's medical records confirmed she had the tracheostomy tube when she was admitted to the facility. Resident #59's Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 05/22/25 did not indicate the resident had a tracheostomy. On 06/26/25 on 12:34 PM, the Director of Nursing confirmed Resident #59's MDS with ARD 05/22/25 was incorrect. She stated the MDS was modified to indicate the resident had a tracheostomy. No further information was provided through the completion of the survey process. b) Resident #88 A review of Resident #88's medical record found she was admitted to the facility on [DATE]. Further review of the record found a nursing admission assessment dated [DATE] which indicated Resident #88 had fallen prior to admission in the last 31- 180 days. A review of the admission Minimum Data Set (MDS) dated found section J1700 B. Indicated the resident had not fall prior to admission in the las two (2) to six (6) months. An interview with the Nursing Home Administrator (NHA) in the afternoon of 06/25/25 confirmed the MDS was inaccurate.

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	06/30/2025

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review and staff interview, the facility failed to complete a new Pre-admission Screening and Resident Review (PASARR) for a resident with a newly evident or a possible serious disorder. This was true for one (1) out of 30 sampled residents reviewed during the Long-Term Care Survey Process. Resident identifier: #35. Facility census: 101 Findings included: a) Resident #35 A record review, completed on 06/24/25 at 6:18 PM, record review revealed: -A physician order which read, Divalproex Sodium Oral Tablet Delayed Release 250 MG (Divalproex Sodium). Give one (1) tablet by mouth two times a day for seizures give with 500 mg tab to equal 750 mg two (2) times a day. -Question #30 Current Diagnosis (Check all that apply) on the Pre-admission Screening and Record Review (PASARR), dated 10/16/24, did not indicate an issue with seizures. During an interview on 06/25/25 at 10:45 AM, the facility Social Worker acknowledged a new PASARR had not been completed to capture the seizure disorder.

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	06/30/2025

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 comprehensive care plan that accurately reflected resident status and need for assistance. This deficient practice had the potential to affect two (2) of 30 residents reviewed in the long-term care survey sample. Resident Identifiers: #62 and #85. Facility census: 101. Findings included: a) Resident #62 Review of Resident #62's comprehensive care plan showed the following focus: - [Resident's name] has impaired cognitive function/dementia or impaired thought processes r/t [related to] poor recall. Psychotropic drug. BIMS [Brief Interview for Mental Status] >12. Date initiated: 05/13/23. Revision on: 08/24/24. The Brief Interview for Mental Status is a standardized assessment used to evaluate cognitive function. The BIMS is scored as follows: 13-15: Cognitively intact. 8-12: Moderate cognitive impairment. 0-7: Severe cognitive impairment. Resident #62's admission Minimum Data Set (MDS) assessment with Assessment Reference Date (ARD) 05/04/23 indicated the resident's BIMS score was 3. Resident #62's most recent quarterly MDS with ARD 05/15/25 also indicated the resident's BIMS score was 3. On 06/26/25 at 11:00 AM, the Director of Nursing (DON) confirmed Resident #62's comprehensive care plan was incorrect and the resident had never had a BIMS score of 12 during his time at the facility. The DON provided documentation that when Resident #62's comprehensive care plan was initially developed on 05/15/23, the focus stated, [Resident's name] has impaired cognitive function/dementia of impaired thought process r/t BIMS less than 12. Psychotropic drug use. The DON stated when the resident's care plan was later revised, the resident's BIMS score was incorrectly documented. No further information was provided through the completion of the survey process. b) Resident #85 (continued on next page)

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	06/30/2025

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	An observation of the noontime meal on 06/24/25 found Resident #85 was feeding himself with his fingers. He was eating Turkey Tex Mex which contained rice, and bake beans. The resident was dropping food on his clothes. An additional observation of the noon time meal on 06/25/25 found the resident again feeding himself with his fingers. He ate a piece of pineapple upside down cake with his hands. He also had on his plate mashed potatoes , chopped broccoli and ground meatballs with gravy. He attempted to eat some mashed potatoes but had difficulty. An observation of his dining area found there was cake crumbs and bits of food scattered around the floor. He then left the dining room. During the observations no staff member was observed telling the resident to use his utensils. An interview with Nurse Aide (NA) #13 and NA #78 at 12:00 PM on 06/25/25 confirmed the resident always uses his hands to feed himself. They indicated the resident can use utensils but he requires constant supervision and queuing to use the utensils. NA # 13, stated It has to be one on one. The both agreed that once he gets started using his utensils he does very well. An interview with the speech therapist at 1:45 PM on 06/25/25 confirmed the resident does very well when you get him started with his utensils. She indicated once you show him the utensils and get him started he will finish eating and will do very well. A review of Resident #85's care plan found the following related to eating: Eating Assist: The res requires Set-Up, w/ eating. This was added to the care on 05/11/24 and was the active intervention at the time of this review. This confirmed with the Director of Nursing (DON) on the afternoon of 06/25/25.

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	06/30/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, resident interview, record review, and staff interview, the facility failed to revise the comprehensive care plan to reflect the resident's choices and when a resident's medication dosages changed. This deficient practice had the potential to affect two (2) of 30 residents reviewed in the long-term care survey sample. Resident Identifier: #75 and Resident #101. Facility census: 101. Findings included: a) Resident #75 On 06/24/25 at 9:30 AM, Resident #75 was noted to have an indwelling urinary catheter. The urine collection bag was hanging from the resident's bed but did not have a privacy cover to prevent the urine in the bag being seen by others. On 06/24/25 at 10:02 AM, the Director of Nursing (DON) stated Resident #75 refused to have a privacy bag placed on the urine collection bag for his catheter. She stated this was reflected in the resident's comprehensive care plan. Review of Resident #75's comprehensive care plan showed the following focus, initiated on 05/16/23, [Resident's name] has a suprapubic Catheter d/t [due to] neurogenic bladder. Interventions for the focus were as follows: - [Resident's name] has a 18Fr [French] suprapubic catheter with a 10mL [milliliter] balloon. Position catheter bag and tubing below the level of the bladder and away from entrance room door. Date Initiated: 05/16/2023 Revision on: 09/17/2024 - Change catheter bag as needed. Date Initiated: 05/16/2023 Revision on: 09/17/24 - Change dressing to suprapubic cath [catheter] site Q [every] shift per order. Date Initiated: 04/09/2024 Revision on: 09/17/2024 - Change suprapubic catheter when occluded or unable to flow freely as needed. Date Initiated: 05/16/2023 (continued on next page)

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	06/30/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Revision on: 09/17/2024 - Enhanced Barrier Precautions for suprapubic catheter. Date Initiated: 09/19/2023 Revision on: 09/17/2024 - Flush catheter as ordered. See TAR [treatment administration record]. Date Initiated: 06/22/2024 Revision on: 09/17/2024 - Monitor and document intake and output as per facility policy Promote good fluid intake. Date Initiated: 05/16/2023 Revision on: 09/17/2024 - Monitor for s/sx [signs and symptoms] of discomfort on urination and frequency. Date Initiated: 05/16/2023 Revision on: 09/17/2024 - Monitor/document for pain/discomfort due to catheter. Date Initiated: 05/16/2023 Revision on: 09/17/2024 - Monitor/record/report to MD for s/sx UTI [urinary tract infection]: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Date Initiated: 05/16/2023 Revision on: 09/17/2024 On 06/25/25 at 3:00 PM, Resident #75 confirmed he did not want a privacy bag on his urine collection bag. On 06/26/25 at 12:45 PM, the Director of Nursing was asked to identify where Resident #75's comprehensive care plan documented the resident chose not to have a privacy bag for his urine collection bag. (continued on next page)

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	06/30/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/25 at 1:07 PM, the Director of Nursing provided a copy of Resident #75's comprehensive care plan which had been revised as follows: - Change catheter bag as needed. Resident refuses to allow catheter cover to be placed. Date Initiated: 05/16/23 Revision on: 06/26/25 No further information was provided through the completion of the survey. b) Resident #101 Review of Resident #101's physician's orders showed the following orders: - Seroquel oral tablet 25 milligrams (mg) (Quetiapine Fumarate) two (2) times a day, ordered 04/25/25 and discontinued 05/15/25. - Seroquel oral tablet 25 mg (Quetiapine Fumarate) one (1) time a day, ordered 05/16/25 and discontinued 05/22/25. - Seroquel oral tablet 50 mg (Quetiapine Fumarate) one (1) time a day, ordered 05/16/25 and discontinued 05/22/25. - Seroquel oral tablet 25 mg (Quetiapine Fumarate) two (2) times a day, ordered 5/22/25. This was the resident's current order. - Hydroxyzine (Vistaril), 75 mg by mouth every eight (8) hours as needed, ordered 04/30/25 for 14 days, renewed 05/15/25, and discontinued 05/21/25. - Hydroxyzine (Vistaril), 75 mg by mouth three times a day, ordered 05/21/25. This was the resident's current order. Resident #101's comprehensive care plan contained the following foci: - Altered Psychosocial needs r/t [related to] Dementia. [Resident's name] is on Seroquel 50 mg q [every] hs [night] and 25 mg in the morning, hydroxyzine 75 mg q 8 hours prn [as needed]. Date Initiated: 03/26/2025 Revision on: 05/16/2025 - The resident uses anti-anxiety medications (Vistaril PRN) r/t Anxiety disorder. Date Initiated: 04/19/2025 Revision on: 04/19/2025 (continued on next page)

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	06/30/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/30/25 at 12:46 PM, the Director of Nursing confirmed Resident #101's care plan was not revised when the Seroquel (Quetiapine Fumarate) dosage change was ordered and when the Hydroxyzine (Vistaril) was ordered to be administered around-the-clock instead of as needed. No further information was provided through the completion of the survey.

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	06/30/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. . Based on observation, staff interview and record review the facility failed to ensure Resident #85's care plan accurately reflected the level and type of assistance he needed for eating. This was true for one (1) of five (5) residents reviewed for the care area of Activities of Daily Living (ADL) during the long term care survey process. Resident Identifier: #85. Facility Census:101. Findings Include: a) Resident #85 An observation of the noontime meal on 06/24/25 found Resident #85 was feeding himself with his fingers. He was eating Turkey Tex Mex which contained rice, and bake beans. The resident was dropping food on his clothes. An additional observation of the noon time meal on 06/25/25 found the resident again feeding himself with his fingers. He ate a piece of pineapple upside down cake with his hands. He also had on his plate mashed potatoes , chopped broccoli and ground meatballs with gravy. He attempted to eat some mashed potatoes but had difficulty. An observation of his dining area found there was cake crumbs and bits of food scattered around the floor. He then left the dining room. During the observations no staff member was observed telling the resident to use his utensils. An interview with Nurse Aide (NA) #13 and NA #78 at 12:00 PM on 06/25/25 confirmed the resident always uses his hands to feed himself. They indicated the resident can use utensils but he requires constant supervision and queuing to use the utensils. NA # 13, stated It has to be one on one. The both agreed that once he gets started using his utensils he does very well. An interview with the speech therapist at 1:45 PM on 06/25/25 confirmed the resident does very well when you get him started with his utensils. She indicated once you show him the utensils and get him started he will finish eating and will do very well. A review of Resident #85's care plan found the following related to eating: Eating Assist: The res requires Set-Up, w/ eating. This was added to the care on 05/11/24 and was the active intervention at the time of this review. This confirmed with the Director of Nursing (DON) on the afternoon of 06/25/25.

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	06/30/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and staff interview, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice. Physician orders were not followed for two (2) of 30 residents reviewed in the long-term care survey sample. Resident identifiers: #101 and #33. Facility census: 101. Findings included: a) Resident #101 Review of Resident #101's physician's orders showed an order written on 06/01/25 for the antibiotic Cipro 500 milligrams (mg), by mouth, two (2) times a day for seven (7) days for a urinary tract infection. This would equal 14 doses of Cipro. Resident #101's Medication Administration Record (MAR) showed a notation at bedtime on 06/01/25 that indicated a nursing note had been written regarding the medication. The nursing note stated the medication was not available yet and the physician was aware. The MAR indicated Cipro was administered in the morning and at bedtime on 06/02/25 through 06/07/25. Cipro was administered only in the morning on 06/08/25. This equaled 13 doses of Cipro. On 06/30/25 at 1:53 PM, the Director of Nursing confirmed there was no documentation the resident received 14 doses of Cipro as ordered by the physician. b) Resident #33 Review of Resident #33's order showed the following orders: - Acetaminophen (Tylenol) 325 milligrams (mg), give two (2) tablets by mouth every six (6) hours as needed for general discomfort, ordered 05/26/25. - Hydrocodone-Acetaminophen 5-325 mg, give one (1) tablet by mouth every four (4) hours as needed for pain scale six (6) to 10, ordered 05/22/25. A pain scale is a tool used to help individuals communicate the intensity of their pain. The scale ranges from 0 (no pain) to 10 (worst pain imaginable). Resident #33's MAR showed the resident received acetaminophen on three (3) occasions since the medication was ordered. These occasions were as follows: - 05/26/25 at 2:46 PM, for pain level of 3. - 06/07/25 at 2:01 AM, for pain level of 4. - o6/17/25 at 11:36 AM, for pain level of 4. (continued on next page)

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	06/30/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #33's MAR showed the resident received Hydrocodone-Acetaminophen on 54 occasions since the medication was ordered. On ten occasions, the resident's pain was documented at a lower level than required for administration according to the physician's orders. These occasions were as follows: - 05/23/25 at 11:15 AM, for pain level of 3. - 05/27/25 at 1:00 PM, for pain level of 5. - 05/28/25 at 2:05 PM, for pain level of 5. - 05/31/25 at 8:44 AM, for pain level of 3. - 05/31/25 at 12:50 PM, for pain level of 4. - 05/31/25 at 10:55 PM, for pain level of 5. - 06/01/25 at 11:05 AM, for pain level of 4. - 06/04/24 at 7:50 AM, for pain level of 0. - 06/13/54 at 8:50 AM, for pain level of 5. - 06/21/25 at 2:50 PM, for pain level of 0. On 06/30/25 at 10:32 AM, the Director of Nursing confirmed Resident #33's Hydrocodone-Acetaminophen was administered outside the pain scale parameters ordered by the physician. No further information was provided through the completion of the survey.

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	06/30/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review, and staff interview, the facility failed to ensure the resident's oxygen flow rate was set according to the physician's orders. This deficient practice had the potential to affect one (1) of one (1) residents reviewed for the care area of oxygen. Resident Identifier: #62. Facility census: 101. Findings included: a) Resident #62 On 06/24/25 at 11:18 AM, Resident #62 was observed to be using supplement oxygen therapy via nasal cannula at four (4) liters per minute. Review of Resident #62's physician's orders showed an order written on 12/30/24 for oxygen at two (2) liters via nasal cannula related to: COPD [chronic obstructive pulmonary disorder], respiratory disorder, as needed for short of breath. On 06/25/25 at 11:04 AM, Resident #62 was again observed to be using supplement oxygen therapy via nasal cannula at four (4) liters per minute. On 06/26/25 at 2:03 PM, Licensed Practical Nurse (LPN) #40 confirmed Resident #62's supplemental oxygen therapy was set to four (4) liters per minute. LPN #40 asked the resident if he had adjusted his oxygen rate, and the resident stated, no. LPN #40 set the resident's oxygen flow rate to two (2) liters per minute and stated he would check the resident's oxygen saturation level. No further information was provided through the completion of the survey process.

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	06/30/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview the facility failed to ensure food was stored and prepared in a safe and sanitary manner. This failed practice has the potential to effect more than an isolated number of residents. Facility Census: 101. Findings Include: a) Initial tour of the Kitchen and Pantries An initial tour of the kitchen upon entrance to the facility on [DATE] at 9:15 AM found the kitchen staff had a cyclone floor fan blowing toward the food preparation area. The fan as observed to be covered in dust and was not clean. The dietary manager (DM) stated, I am getting rid of this right now. On the dementia unit in the refrigerator was two (2) bottles of ranch dressing which were open and not dated, a small carton of vitamin D milk which was open and not dated, and a small bag fiesta shredded cheese which was open and not dated. 06/24/25 09:15 am initial tour of the kitchen with the CDM there was a dirty fan sitting on the floor blowing toward the food prep area. The CDM said she was getting it out of here. She said it was just trying to manage the heat with the fan. The DM then stated all the items should have been dated.

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	06/30/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance 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 ensure complete and accurate medical records. The medication diagnosis was inaccurate for two (2) of 30 sampled residents reviewed in the Long-Term Care Survey Process. Additionally, a resident's psychiatric evaluation notes referred to her as a male. This was true for one (1) of 30 sampled residents reviewed in the Long-Term Care Survey Process. Resident identifiers: #40, #101, and #102. Facility census: 101. Findings included: a) Resident #40 A record review, completed on 06/26/25 at 11:15 AM, revealed a physician order for a 5 MG Apixaban tablet noting, Give 1 tablet by mouth two times a day for Pleural Effusion. During an interview on 06/26/25 at 11:48 AM, the Director of Nursing (DON) stated the order was not accurate. The DON noted that the order should have captured PE as a pulmonary embolism. b) Resident #101 Review of Resident #101's physician's orders showed an order written on 04/26/25 for Escitalopram Oxalate (Lexapro) 10 milligrams (mg) by mouth one (1) time a day for dementia. Lexapro is an anti-depressant medication that is also used to treat anxiety disorders. Resident #101 had diagnoses of dementia and anxiety disorder. On 06/30/25 at 12:56 PM, the Director of Nursing (DON) confirmed dementia was not an appropriate diagnosis for Lexapro. The DON stated Resident #101 was receiving Lexapro due to anxiety. No further information was provided through the completion of the survey. c) Resident #102 A review of Resident #102's medical record on 06/25/25 found Resident #102 was seen by a psychiatrist on 05/20/25 and 06/11/25. A review of each evaluation note for 05/20/25 found the following, History of Present Illness: The patient is a [AGE] year-old female presenting with a hx of Dementia and Encephalopathy. The patient is currently residing at Glasgow Hills NF for long-term care. The patient was originally admitted to the facility on [DATE]. Pt denies any significant past psychiatric history, IP/OP psychiatric services, or SA. Medication changes at last visit: initial visit (continued on next page)

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	06/30/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The patient is not able to report when the presenting problem began. Current stressors: Alleviating factors: The patient reports feeling fine and his mood is fine. Pt denies depression and anxiety. Pt denies hallucinations, delusions, and irritability. Pt denies confusion. Pt reports that his sleep is pretty good and his appetite is good. Pt denies SI/HI. BIMS score of 9. The psychiatrist referred to resident #102 as a male three times in the note. A review of the note dated 06/11/25 found the following, History of Present Illness: The patient is a [AGE] year-old female presenting with a hx of Dementia and Encephalopathy. The patient is currently residing at Glasgow Hills NF for long-term care. The patient was originally admitted to the facility on [DATE]. Pt denies any significant past psychiatric history, IP/OP psychiatric services, or SA. Medication changes at last visit: Namenda and Buspar (Checked 06/11/2025) The patient is not able to report when the presenting problem began. Current stressors: Alleviating factors: The patient reports feeling pretty good, and his mood is pretty good. Pt denies depression and anxiety. Pt denies hallucinations, delusions, and irritability. Pt denies confusion. Pt reports that his sleep is pretty good and his appetite is good. Pt denies SI/HI. Again the psychiatrist refers to the female patient as a male. An interview with the Director of Nursing (DON) on 06/25/25 at 11:30 am confirmed the psychiatry note on 05/202/25 and 06/11/25 referred to the female patient as a male. She stated, I will address that with the provider.

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	06/30/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and staff interview, the facility failed to establish and maintain an infection prevention and control program designed to help prevent the development and transmission of communicable diseases and infections. The facility failed to follow Enhanced Barrier Precautions (EBP) for a resident with indwelling medical devices. This was a random opportunity for discovery. Resident Identifier: #59. Facility census: 101. Findings included: a) Resident #59 The facility's policy titled, Enhanced Barrier Precautions, with implementation date 03/20/25 and revision date 03/20/25, stated Enhanced Barrier Precautions (EBP) would be followed for residents with indwelling medical devices including tracheostomy/ventilator tubes and feeding tubes. The policy also stated personal protective equipment would be worn for high-contact resident care activities for residents in EBP. High-contact resident care activities included care of medical devices, including tracheostomy care and feeding tube care. The policy also stated that enhanced barrier precautions may be followed for residents colonized with a multidrug-resistant organism not targeted by the Center for Disease Control but may be considered epidemiologically important. Review of Resident #59's physician's orders showed an order written on 03/18/25 for enhanced barrier precautions for history of Extended-Spectrum Beta-Lactamase (ESBL). The resident also had orders for tracheostomy care and percutaneous endoscopic gastrostomy (PEG) tube care. Outside of Resident #59's room was a sign stating, Stop. Enhanced Barrier Precautions. Everyone must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing Bathing/showering Transferring Changing Linens Providing Hygiene Changing Briefs or assisting with toileting Devise care or use: central line, urinary catheter, feeding tube, tracheostomy Wound care: any skin opening requiring a dressing. (continued on next page)

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	06/30/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/26/25 at 09:20 AM, Licensed Practical Nurse (LPN) #27 was observed providing indwelling medical device care to Resident #59. LPN #27 changed the inner cannula of the resident's tracheostomy. LPN #27 also changed the dressing on the resident's PEG tube and cleaned the PEG tube site. LPN #27 wore gloves for the procedures, but did not wear a gown as was indicated by the facility's EBP policy and procedures. On 06/26/25 at 10:10 AM, the Director of Nursing confirmed gowns were required to be worn by staff performing tracheostomy care and PEG tube care. No further information was provided through the completion of the survey process.