STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185271	A. Building B. Wing	06/04/2025

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Glenview Health and Rehabilitation	1002 Glenview Drive Glasgow, KY 42141

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 4. Review of the Resident Face Sheet for R44 revealed the facility admitted the resident on 06/14/2024, with diagnoses that included cerebral infarction, unspecified, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of R44's Quarterly MDS Assessment, with an ARD date of 03/21/2025, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Review of the physician's orders dated 11/12/2024, revealed an order for R44 to have an L [left] ankle brace placed on L ankle daily to increase support, remove before bed with a start date of 11/12/2024. Continued review of the physician's orders revealed an order for R44 to have L resting hand splint to L hand 4-6 hours daily to avoid contractures to L hand and wrist with a start date of 11/12/2024. Review of R44's care plan revealed the facility identified ADLs Functional Status/Rehabilitation Potential problem dated 11/12/2024, that noted, Resident requires splint/brace assistance to left hand and ankle. Continued review revealed the interventions/approaches stated, Left resting hand splint for a minimum of 4 hours to a maximum of 6 hours as resident will allow. Apply at 10:00 and remove at HS (bedtime). Further review revealed an additional intervention/approach documented to Use left ankle brace apply in AM and remove at HS as resident will allow. Observation on 06/01/25 at 11:00 AM, revealed R44 was up in a wheelchair with no splints observed in use. Observation on 06/02/25 at 9:34 AM, revealed R44 was lying on the bed with no splints observed in use. In interview with R44 on 06/03/2025 at 1:08 PM, the resident stated he had worn the splints last week, but had not worn them on Sunday (06/01/2025) or Monday (06/02/2025). In interview with CNA 5 on 06/03/2025 at 1:10 PM, she stated R44's splints could come off at 2:00 PM and the wear time was from 10:00 AM until 2:00 PM. She further stated she was a PRN (as needed) employee at the facility. 5. Review of R209's Resident Face Sheet revealed the facility admitted the resident on 04/23/2025, with diagnoses that included Atrial Fibrillation, cognitive communication deficit, essential hypertension and heart failure. Review of R209's admission MDS Assessment, with an ARD of 04/27/2025, revealed the facility (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed the resident to have a BIMS score of 12 out of 15, indicating moderate cognitive impairment. Review of R209's medical record revealed the resident sustained falls three falls since admission without major injury: on 05/06/2025 at 3:34 PM; 05/12/2025 at 7:40 PM; and 05/15/2025 at 1:00 PM. Review of R209's care plan revealed the facility identified a problem for Falls with a start date of 04/24/2025, noting the resident was at risk for falling related to weakness with a history of falls. Continued review of the care plan revealed an intervention dated 05/13/2025, that stated, apply bright color call tape to remind [R209] to call for help before self-ambulating. Observation of R209's room on 06/01/2025 at 9:22 AM; on 06/03/2025 at 11:10 AM; and on 06/04/2025 at 10:15 AM, revealed the resident had a standard call light and a touch pad call light located at bedside. Observation of the touch pad call light revealed it was white with a manufacturer-applied red symbol. Further observation revealed neither of the call lights had any brightly colored tape on them as per R209's Falls care plan intervention with the start date of 05/13/2025. In interview with the MDS Coordinator on 06/04/25 05:30 PM, she stated updating residents' care plans were part of her responsibility and the development of care plan interventions was an interdisciplinary team (IDT) effort. She said she was unsure if she had placed the intervention for brightly colored tape on R209's care plan. The MDS Coordinator reported if a resident's fall occurred on the weekend, interventions could be put on the care plan in real time by all nurses. She stated she would expect that we would follow up to see that the intervention had been put in place; however, said there was no one person responsible to follow up to ensure the intervention was in place. The MDS Coordinator stated she would expect an intervention to be in place and implemented if it was on the resident's care plan. In interview with the Assistant Director of Nursing (ADON) on 06/04/25 at 10:16 AM, she stated if an intervention for colored tape was on the resident's care plan, then one should see some the tape on the call light. She said a touch pad call light would not be substituted for the colored tape on the call light. The ADON further stated the colored tape was used to remind the resident to use the call light to call for assistance. In interview with the DON on 06/04/2025 at 5:52 PM, she stated that she would consider the touch pad as brightly colored as it had the red lettering. She said she considered a brightly colored item to be different than the item itself though. The DON reported a clinical meeting was held in the morning to review residents' falls and to review the interventions recommended to address the fall. She further stated following the morning clinical meeting, a list of items to follow up on was distributed to each nurse's station and a stand down meeting was conducted in the afternoon to follow up to ensure the items on the list were in place and completed. In interview with the Administrator on 06/04/2025 at 5:57 PM, stated she would have to consult with someone to know if a touch pad call light with red lettering was equivalent to brightly colored tape. She said at the end of the day a stand down meeting was completed with the list taken to floor staff after the morning clinical meeting to ensure the items on the list were followed up on. Based on observation, interview, record review, and facility policy review, it was determined the facility failed to implement a comprehensive person-centered care plan for 4 of 7 residents sampled for orthotic devices, out of the total sample of 23, (Residents (R)15, R22, R44, and R45. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additionally, the facility failed to develop the comprehensive person-centered care plan with an intervention for applying bright colored tape to R209's call light. The findings include: Review of the facility policy, Comprehensive Care Plans revised on 02/2025, revealed it was the facility's policy to develop and implement a comprehensive person-centered care plan for each resident to meet a resident's medical, physical, mental, and psychosocial needs. Continued review revealed the care plan was to describe any services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Per review, the care plan was also to have resident specific interventions that reflected the resident's needs. Review of the policy revealed the qualified staff responsible for carrying out the interventions were to be notified of their roles and responsibilities for carrying out the interventions initially and when changes were made. Further review revealed the comprehensive care plan was to be reviewed and revised by the interdisciplinary team (IDT) after each comprehensive and quarterly Minimum Data Set (MDS) Assessment. 1. Review of the Resident Face Sheet for R22 revealed the facility admitted the resident on 04/03/2020, with diagnoses of unspecified dementia, unspecified severity with other behavioral disturbance, drug-induced subacute dyskinesia and bipolar disorder. Review of the Annual MDS Assessment with an Assessment Reference Date (ARD) of 03/11/2025, revealed the facility had not completed a Brief Interview for Mental Status (BIMS) assessment as R22 was rarely or never understood. Review of R22's Comprehensive Care Plan dated 11/12/2024, revealed the facility had developed a focus problem for ADL-Functional status, resident required splint/brace assistance to the left hand. Continued review revealed an intervention dated 11/12/2024, to apply left resting hand splint minimum 4 hours daily to maximum of six hours daily as resident would allow. Further review revealed additional interventions to explain to the resident the splint brace schedule, correct splint/brace application and how to assess the skin, monitor for presence of pain, muscle spasm, during range of motion. Further review revealed there were no interventions for range of motion to be performed on the care plan. Observation on 06/01/2025 at 10:25 AM and 1:48 PM, of R22 revealed she was not wearing a hand splint. Observation on 06/02/2025 at 9:50 AM and 10:32 AM, revealed R22 had no hand splint in place. In addition, observation on 06/03/2025 at 10:20 AM and 1:00 PM, revealed a resting hand splint observed in a chair in the resident's room. In interview with Certified Nursing Assistant (CNA) 3 on 06/04/2025 at 9:23 AM, she stated R22's splints were on the resident's care plan which noted the splints were to be worn four to six hours daily. She reported the aides were responsible for applying (residents') splints and said she did not perform range of motion (ROM) for the resident prior to applying the splint. CNA 3 stated R22 had a hand splint that she (CNA) was supposed to put on the resident at 10:00 AM; however, the resident did not receive ROM before the application. She further stated residents not wearing their splints could make their contractures worse. 2. Review of the Resident Face Sheet R15 revealed the facility admitted the resident on 02/20/2017, with diagnoses of Alzheimer's Disease, chronic obstructive pulmonary disease and vascular dementia. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Annual MDS Assessment, with an ARD of 03/28/2025, revealed had not completed a Brief Interview for Mental Status (BIMS) assessment as R15 was rarely or never understood. Review of R15's Comprehensive Care plan dated 11/12/2024, revealed the facility identified a focus for ADL's functional status, that noted the resident required splint/brace assistance to the left hand. Continued review revealed an intervention dated 11/12/2024, documenting to apply the left hand grip splint for a minimum of four hours daily to a maximum of six hours, as resident would allow. Further review revealed the goal for R15 was for the left hand to be free from injury, skin breakdown and edema. Observation on 06/01/2025 at 10:46 AM and 1:59 PM, of R15 revealed a hand splint in a mesh bag lying on the bedside table. Observation on 06/02/2025 at 10:47 AM and 1:35 PM, revealed the splint remained lying on the bedside table in a mesh bag. Additionally, observation on 06/03/2025 at 9:25 AM and 1:48 PM, revealed the splint remained lying on the bedside table. 3. Review of the Resident Face Sheet for R45 revealed the facility admitted the resident on 03/18/2024, with diagnoses that included hemiplegia, and hemiparesis following unspecified cerebrovascular disease affecting left side. Review of the Annual MDS Assessment, with an ARD of 3/26/2025, revealed the facility assessed R45 to have a BIMS score of 14 out of 15, indicating the resident was cognitively intact. Review of the Comprehensive Care Plan dated 11/13/2024 for R45, revealed the facility identified a focus problem for ADLs, that noted the resident required splint/brace assistance to the left hand. Further review revealed an intervention dated 11/13/2024, that read to apply resting hand splint to the resident's left hand four to six hours daily. Observation of R45 on 06/04/2025 at 12:42 PM, revealed she had a resting hand splint on her left hand. In interview at the time of observation, R45 reported, today was the first time in about four months that her hand splint had been applied. She stated she did not receive range of motion (ROM) to the hand prior to the splint being applied and had discomfort when it was first applied. R45 said she wore the splint for about four hours if staff don't forget to come and take it off. She further stated Licensed Practical Nurse (LPN) 2 had to search her closet that morning to find the splint so it could be put on. The SSA Surveyor requested a policy on orthotic devices or splinting, and a policy on Restorative Nursing Services on 06/02/2025 at 2:18 PM. However, the Administrator stated the facility had no policy for Restorative Nursing Services or a policy on splinting. In interview with CNA 2 on 06/02/2025 at 12:17 PM, she stated she had been working at the facility for one month. CNA 2 said for her to view a resident's care plan she would look at the care plan in the facility's computer system. She stated the care plan would show what kind of care a resident would need. CNA 2 reported she did not apply resting hand splints to residents and guessed the nurse did that. She further stated resting hand splints should be located on the residents' care plans if a resident was supposed to wear them. In interview with CNA 4 on 06/04/2025 at 9:36 AM, she stated the CNA's were responsible for applying residents' hand splints. She reported she seldom worked on the hall she was currently assigned and therefore, did not know which residents had splints. CNA 4 further stated if a resident had splints (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or devices information on those should be on the resident's care plan. In interview with the MDS Coordinator on 06/04/2025 5:30 PM, she stated updating the care plan was part of her responsibility and interventions on the residents' care plans were expected to be in place and followed. She further stated staff were made aware of residents' care plan interventions by accessing the care guide on the computer. In interview with the Director of Nursing (DON) and the Administrator on 06/04/2025 at 5:52 PM, the DON stated she was new to her position and was still learning her duties. The DON stated expectations were for staff to follow what was on residents' care plans and implement them. The Administrator stated she expected staff to do whatever was in the best interest of the patient (resident) and follow their plan of care.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and review of facility policy, the facility failed to meet professional standards of quality during medication administration for 1 of 3 sampled resident out of the 23 total sampled residents (Resident (R)51). The findings include: Review of the facility policy titled, Medication Administration, last revised date of 02/20/2025, revealed medications were to be administered as ordered by the physician and in accordance with professional standards of practice. Further review of the policy revealed the Compliance Guidelines included obtaining and recording vital signs when applicable and holding medication for vital signs outside the physician's prescribed parameters. Review of R51's Resident Face Sheet revealed the facility admitted the resident on 10/31/2024, with diagnosis that included essential hypertension, Alzheimer's disease, and chronic kidney disease. Review of the physician's orders dated 10/31/2024 revealed an order for Lisinopril 20 milligram (mg) one tablet daily which was to be held if the resident's systolic blood pressure was less than 150 mm hg (millimeters of mercury). Observation of CMT 1 administering medication for R51 on 06/03/2025 at 9:22 AM, revealed the CMT assessed R51's manual blood pressure a 132/60. Continued observation revealed CMT 1 proceeded to administer Lisinopril (blood pressure medication) 20 milligrams (mg) to R51, and returned to the medication cart to document the administration of the medication. Per observation, CMT 1 reviewed the parameters for the blood pressure and indicated the medication should not have been administered as the prescribed parameters were to hold the medication if the systolic blood pressure was less than 150. CMT 1 stated she would notify the nurse who would then contact the physician for further instructions. Review of the medication bingo card that held the Lisinopril 20 mg tablets revealed the medication was dated 5/03/2025 with 22 of 30 doses remaining on the card indicating 18 doses had been administered since 05/03/2025. Review of the Medication Administration Record (MAR) for the month of May 2025 revealed the medication was held for 10 of 31 days due to R51's blood pressure reading. However, further review of the MAR revealed the medication was administered 21 days although the maximum recorded blood pressures was 136 mm hg, which was below the 150 mm hg parameters ordered by the physician. Review of the MAR for the month of June 2025 revealed Lisinopril 20 mg was administered 06/01/2025, 06/02/2025, and 06/03/2025 with all three systolic blood pressure readings measuring less than 150 mm hg. In additional interview with CMT 1 on 06/03/2025 at 9:25 AM, she stated most of the parameters for holding blood pressure medication started at 120 mm hg. She further stated she thought that was what R51's parameters had been as well. In interview on 06/03/2025 at 9:38 AM, Licensed Practical Nurse (LPN) 1, who was assigned to R51, after being notified of the resident's blood pressure medication being administered in error, stated (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she would notify the physician of the error. The LPN further stated she would begin monitoring R51's blood pressure every 30 minutes and go from there. In interview on 06/03/2025 at 9:55 AM, the Assistant Director of Nursing (ADON) stated the physician had been notified. The ADON further stated a new order defining the parameters for administering R51's Lisinopril 20 mg had been changed to hold for a blood pressure less than 110/60. In interview with the Director of Nursing (DON) on 06/04/2025 at 5:45 PM, she stated usually a systolic reading of 110 was a common parameter for holding antihypertensive medication. The DON further stated she would expect staff to follow the physician's orders. In interview with the Administrator on 06/04/2025 at 5:49 PM, stated she expected staff to do whatever is in the best interest of the patient and within their nursing scope.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 3 of 7 residents sampled for range of motion (ROM) and orthotic devices out of the 23 total sampled residents, (Resident (R)15, R45 and R22). The finding include: In interview on 06/02/2025 at 2:18 PM, the Administrator informed the State Survey Agency (SSA) Surveyor the facility did not have a policy for splinting/orthotic devices, or for Restorative Nursing Services. 1. Review of the Resident Face Sheet for R45 revealed the facility admitted the resident on 03/18/2024, with diagnoses that included hemiplegia, and hemiparesis following unspecified cerebrovascular disease affecting the left side. Review of the Annual Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 3/26/2025, revealed the facility assessed R45 to have a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating the resident had intact cognition. Review of R45's physician order dated 11/13/2024, revealed to apply a resting hand splint to the resident's left hand four to six hours daily, once a day from 7:00 AM to 7:00 PM. Observation of R45 on 06/04/2025 at 12:42 PM, revealed the resident had a left resting hand splint in place. In interview on 06/04/2025 at 12:42 PM, R45 stated 'today was the first time in about four months her hand splint had been applied. She reported ROM was not performed to the hand prior to it being applied and said she had discomfort when the splint was first applied. R45 said she wore the splint for about four hours when staff did not forget to come and take it off. She additionally stated Licensed Practical Nurse (LPN) 2 had to search in her closet that morning to locate the splint so it could be applied. 2. Review of the Resident Face Sheet revealed the facility admitted R15 on 02/20/2017, with diagnoses of vascular dementia, Alzheimer's Disease, and chronic obstructive pulmonary disease. Review of the Annual MDS Assessment with an ARD of 03/28/2025, revealed the facility was unable to perform the BIMS assessment as R15 was rarely or never understood. Review of the physician order dated 04/26/2024, revealed an order for R15 to have Physical Therapy (PT) and Occupational Therapy (OT) evaluate and treat the resident for establishment of a restorative nursing program (RNP). Review of the physician order dated 11/12/2024 and which was discontinued on 06/02/2025, revealed an order to apply left hand grip splint daily four to six hours between the hours of 7:00 AM and 7:00 PM daily. Review of the, Occupational Therapy - Evaluation and Treatment Plan, dated 09/26/2024, revealed R15 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had been referred to OT due to increased right upper extremity contracture and pain in the elbow and hand. Continued review revealed R15 had functional limitations present due to the contracture. Further review revealed as a result of the contracture and pain in R15's right upper extremity, OT was to address the contracture impairment. Review of the, Occupational Therapy Discharge Summary, dated 10/24/2024, revealed OT recommended R15 wear a splint as much as tolerated. Per review, a Restorative Nursing Program (RNP) and functional maintenance were not indicated at that time. Further review revealed maintaining R15's current level of function was good with consistent staff follow through. Observation of R15 on 06/01/2025 at 10:46 AM and 1:59 PM, revealed a hand splint in a mesh bag lying on the bedside table. Observation on 06/02/2025 at 10:47 AM and 1:35 PM, revealed the splint remained on R15's bedside table in a mesh bag. Observation on 06/03/2025 at 9:25 AM and 1:48 PM, further revealed the splint continued to be lying on the bedside table. Review of a physician order dated 06/04/2025, revealed an order to, apply right hand grip splint daily for a minimum of four hours with a maximum of six hours daily. Further review of the order revealed the splint was to be placed on R15 at 10:00 AM, and remove the splint at 2:00 PM. 3. Review of the Resident Face Sheet for R22 revealed the facility admitted the resident on 04/03/2020, with diagnoses of unspecified dementia, unspecified severity with other behavioral disturbance, drug-induced subacute dyskinesia and bipolar disorder. Review of the Annual MDS Assessment with an ARD of 03/11/2025, revealed a BIMS assessment was not completed as R22 was rarely or never understood. Review of the physician's order dated 11/12/2024, revealed R22 was to wear a left resting hand splint four to six hours daily, once a day from 7:00 AM to 7:00 PM. Review of the, Occupational Therapy Evaluation and Plan of Treatment, dated 03/03/2025, revealed R22 had been referred to skilled OT services due to increased contractures requiring splinting and ROM resulting in decreased quality of life and pain. Continued review revealed R22 would benefit from skilled OT services to decrease pain and contracture and to increase the resident's overall quality of life. Further review revealed the recommendation noted, splint orthotic recommendations will be assessed and an exercise prescription was for range of motion passive to left upper extremity. Review of the OT Discharge summary dated [DATE], revealed R22's goals had been discontinued as the resident had been discharged to the hospital. Observation on 06/01/2025 at 10:25 AM and 1:48 PM, of R22 revealed the resident was not wearing a hand splint. Observation on 06/02/2025 at 9:50 AM and 10:32 AM, revealed R22 had no hand splint in place. Further observation on 06/03/2025 at 10:20 AM and 1:00 PM, revealed R22 had a resting hand splint lying on a chair in the resident's room. In interview on 06/02/2025 at 12:17 PM, Certified Nursing Assistant (CNA) 2 stated she had been at the facility for a month, and had not applied resting hand splints to residents. She said she guessed the nurse did that (applied the splints). CNA 2 further stated resting hand splint application should be located on the CNA task charting if they were to put them on residents. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In interview on 06/02/2025 at 1:28 PM, Certified Medication Tech (CMT) 1 stated the nurse was responsible for applying hand splints to residents. She said she could not give specific information on splinting or on the residents who had splints, as she did not usually work the floor. In interview on 06/03/2025 at 1:08 PM, the Director of Rehabilitation (DOR), who was an Occupational Therapy Assistant (OTA), stated she had been at the facility for three years. She reported she did not know off hand which residents had orthotics (splints) and she would have to look that information up. The DOR said no residents were receiving ROM programs as the facility did not have restorative nursing services. She stated when a resident was discharged from therapy services the resident's therapy needs were turned over to the nursing staff. The DOR explained the techs and nurses received education regarding a resident's how to apply and remove any orthotic device. She further stated there was no specific time of day the orthotics had to be applied and removed; however, residents should wear them at least four to six hours or as tolerated. In interview on 06/04/2025 at 9:23 AM, CNA 3 stated the facility did not have a restorative nursing program. She stated she had been informed that morning that R22 had a hand splint she was supposed to put on at 10:00 AM, but the resident did not receive ROM on the hand. The CNA showed the State Survey Agency (SSA) Surveyor where the information on R22's splint was located in the computer. Review of the computer information revealed it showed that CNA 3 was to document the application of the splint at 10:00 AM. Further review of the computer documentation revealed R22's splint had not been documented as applied in the computer since 06/01/2025. CNA 3 further stated in interview that residents not wearing their splints could make their contractures worse. In interview on 06/04/2025 at 9:36 AM, CNA 4 stated the facility had no official restorative nursing program and no restorative nursing assistants. She stated residents received ROM during their ADL care, such as dressing. CNA 4 reported the CNAs were responsible for applying residents' hand splints. She further stated she seldom worked on the hall she was currently working on, and did not know which residents had splints. In interview on 06/04/2025 at 5:52 PM, with the Director of Nursing (DON) and the Administrator, the DON stated she was new to her position, but said her expectations were for staff to follow physician orders. She said the facility did not have restorative nursing; however, residents received ROM through walking, dressing, and transfers. The DON further stated if residents did not have their devices on and did not receive ROM, they could potentially experience a decline in mobility causing contractures. The Administrator stated she expected staff to do whatever was in the best interest of the patient (resident) and follow the physician orders. Surveyor: [NAME], [NAME]

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	185271	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenview Health and Rehabilitation	1002 Glenview Drive Glasgow, KY 42141

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents with limited range of motion (ROM) received appropriate treatment and services to prevent further decrease in ROM for 3 of 7 residents sampled for limited ROM out of the 23 total sampled residents, (Resident (R15), R22, and R45). The findings include: In interview on 06/02/2025 at 2:18 PM, the Administrator informed the State Survey Agency (SSA) the facility did not have a policy regarding Restorative Nursing Services or splinting/orthotic devices. 1. Review of the Resident Face Sheet revealed the facility admitted R45 on 03/18/2024, with diagnoses that included hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left side, and personal history of transient ischemic attack. Review of the Annual Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 03/26/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 14 out of 15, indicating R45 was cognitively intact. Review of the physician order for R45 dated 11/13/2024, revealed staff were to apply the resident's resting hand splint to the left hand for four to six hours daily, once a day from 7:00 AM to 7:00 PM. Observation of R45 on 06/04/2025 at 12:42 PM, revealed the resident had a left resting hand splint in place. In interview at the time of observation, R45 stated that day was the first time the hand splint had been applied in about four (4) months. She said she did not receive range of motion (ROM) from to the hand before staff put it on. The resident reported she had discomfort of the left hand when the splint was first applied. She stated she wore the splint for about four hours, when staff did not forget to come and take it off. R45 further stated Licensed Practical Nurse (LPN) 2 had to search her closet that morning to find the splint to have it put on. 2. Review of the Resident Face Sheet revealed the facility admitted R15 to the facility on [DATE], with diagnoses of Alzheimer's Disease, chronic obstructive pulmonary disease, and vascular dementia. Review of the Annual MDS Assessment with an ARD of 03/28/2025, revealed the facility had not completed the Brief Interview for Mental Status (BIMS) assessment of R15 as the resident was rarely or never understood. Review of the physician order dated 04/26/2024 for R15, revealed an order for Physical Therapy (PT) and Occupational Therapy (OT) to evaluate and treat the resident for establishment of a restorative nursing program (RNP). Review of the physician order dated 11/12/2024 for R15, that was discontinued on 06/02/2025, revealed an order for staff to apply the resident's left hand grip splint daily four to six hours between the hours of 7:00 AM and 7:00 PM daily. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of R15 on 06/01/2025 at 10:46 AM and 1:59 PM; on 06/02/2025 at 10:47 AM and 1:35 PM; and on 06/03/2025 at 9:25 AM and 1:48 PM, revealed a hand splint in a mesh bag was lying on the bedside table. Review of the physician order dated 06/04/2025 for R15, revealed an order for staff to apply the resident's right hand grip splint daily for a minimum of four hours with a maximum of six hours daily. Further review of the order revealed the splint was to be put on at 10:00 AM, and removed at 2:00 PM. Review of the Occupational Therapy (OT) - Evaluation and Treatment Plan, dated 09/26/2024, revealed R15 had been referred to OT due to increased right upper extremity contracture and pain in the elbow and hand. Continued review revealed R15 had functional limitations present due to the contracture. Further review revealed as a result of the contracture and pain in the right upper extremity, OT was to address contracture impairment. Review of the Occupational Therapy Discharge Summary, dated 10/24/2024, revealed OT's recommendations were for the resident to wear a splint as much as tolerated. Per review, a Restorative Nursing Program (RNP) was not indicated at that time, and maintaining R15's current level of functioning was good with consistent staff follow through. 3. Review of the Resident Face Sheet revealed the facility admitted R22 on 04/03/2020, with diagnoses of dementia, unspecified severity with other behavioral disturbance, drug-induced subacute dyskinesia and bipolar disorder. Review of the Annual MDS Assessment with an ARD of 03/11/2025, revealed the facility did not complete a BIMS assessment as R22 was rarely or never understood. Review of the physician's order dated 11/12/2024 for R22 revealed an order for the resident to wear a left resting hand splint four to six hours daily, once a day from 7:00 AM to 7:00 PM. Review of the Occupational Therapy (OT) Evaluation and Plan of Treatment dated 03/03/2025, revealed R22 had been referred to skilled OT services due to increased contractures requiring splinting and ROM resulting in decreased quality of life and pain for the resident. Continued review revealed R22 would benefit from skilled OT services to decrease pain and contracture and increase overall quality of life. Further review revealed the OT noted the splint orthotic recommendations were to be assessed and an exercise prescription for passive ROM to R22's left upper extremity. Review of the OT Discharge summary dated [DATE], revealed R22's goals had been discontinued as the resident had been discharged to the hospital. Observation of R22 on 06/01/2025 at 10:25 AM and 1:48 PM, and on 06/02/2025 at 9:50 AM and 10:32 AM, revealed the resident was not wearing a hand splint. Further observation on 06/03/2025 at 10:20 AM and 1:00 PM, revealed R22 had a resting hand splint located in a chair in the resident's room. In interview with Certified Nursing Assistant (CNA) 2 on 06/02/2025 at 12:17 PM, she stated she did not apply residents' resting hand splints, and she guessed the nurse did that. She further stated resting hand splints should be on the CNA task charting if the CNAs were to put them on. In interview with Certified Medication Tech (CMT) 1 on 06/02/2025 at 1:28 PM, she stated the nurse (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was responsible for applying hand splints for residents. She further stated she did not usually work the floor and was unable to give specific information on which residents had splints or on applying the splints. In interview on 06/03/2025 at 1:08 PM, the Director of Rehab (DOR), who was an Occupational Therapy Assistant (OTA), stated she had been working at the facility for three years. She said she did not know off hand which residents had orthotics (splints) and she would look that information up. The DOR reported there were no residents receiving ROM programs, as the facility did not have restorative nursing services. She stated when a resident was discharged from therapy services the resident's care needs were turned over to the nursing staff. The DOR said the techs and nurses received education regarding residents' orthotic devices, such as on how to apply and remove an orthotic. She further stated there was no specific time of day the orthotics had to be applied and removed; however, residents should wear them four to six hours or as tolerated. In interview with CNA 3 on 06/04/2025 at 9:23 AM, she stated the facility did not have restorative nursing programs. She stated she had been informed that morning that R22 had a hand splint that she was supposed to put on at 10:00 AM. CNA 3 said R22 did not receive ROM though. She further stated residents not wearing their splints could cause their contractures worsen. In interview with CNA 4 on 06/04/2025 at 9:36 AM, she stated the facility did not have an official restorative nursing programs and had no restorative nursing assistants. She stated residents received ROM during their ADL care, such as dressing. CNA 4 said the CNAs were responsible for applying residents' hand splints. She further stated she seldom worked on R22's hall and did not know which residents had splints. In interview with the Director of Nursing (DON) and the Administrator on 06/04/2025 at 5:52 PM, the DON stated she was new to the position and was still learning. The DON said her expectations were for staff to follow physician orders. She stated the facility did not have restorative nursing; however, the residents received ROM through walking, dressing, and transfers. The DON further stated residents without their devices and with no ROM could potentially have a decline in mobility causing contractures. The Administrator stated she would expect staff to do whatever was in the best interest of the patient (resident) and follow the physician orders.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, the facility failed to provide a communication system that relayed the call directly to a staff member or to a centralized staff work area from toileting and bathing facilities. The findings include: Review of the facility policy titled, Call Lights: Accessibility and Timely Response, with a revision date of 08/30/2024, revealed the purpose of the policy was to ensure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Per policy review, the call system must be accessible to the resident at each toilet and bath or shower facility and should be accessible to a resident lying on the floor. Observation of the private bathroom in resident room [ROOM NUMBER] on 06/01/2025 at 10:30 AM, revealed a walk-in shower situated to the left immediately upon entering the bathroom. Per observation, to the right, upon entry, a sink and countertop were present. Continued observation revealed parallel to the furthest wall of the bathroom and to the right corner, the toilet was installed with the call light devices installed on the wall that ran parallel to the right of the toilet. Further observation revealed the call light cord was in place and was within approximately one inch from the floor, and the distance from the call light cord to the shower was approximately five feet. Additional observation of the private bathrooms in rooms [ROOM NUMBER] revealed one call light available that was positioned next to the toilet, the same as in room [ROOM NUMBER]. Observation on 06/03/2025 at 1:10 PM, of a resident and staff accessible restroom located on the 300 hall, situated between rooms [ROOM NUMBERS], revealed the presence of a call light system installed in the wall next to the toilet. Further observation revealed however, no pull cord was attached to activate the call light. Observation of the therapy gym on 06/03/2025 at 1:08 PM, revealed the restroom located in that area, had no call light system in place in the restroom. In interview with the Director of Rehabilitation (DOR), at the time of observation, the Director stated residents were never left alone in the restroom in the therapy gym restroom as a therapy staff member was always present. In interview on 06/01/2025 at 10:27 AM, Resident (R)14 expressed concern that the call light cord did not reach the shower in the private bathroom of the room. The resident reported if someone taking a shower had a fall, they would not be able to reach the call light cord to call for help. In interview with Certified Nursing Assistant (CNA) 9 on 06/02/2025 at 11:34 AM, she stated, due to the call lights, she would remain in the room with a resident while the resident was taking a shower, so they did not fall and hurt themselves. In interview with the Assistant Director of Nursing (ADON) on 06/03/2025 at 1:12 PM, she stated that if a resident chose to shower independently and a call light was not within reach, she would probably stand outside the bathroom door to hear if in case the resident fell or called out for help. In interview with the Director of Nursing (DON) on 06/04/2025 at 6:02 PM, she stated she expected staff to know if a resident was in the shower and increase checking on the resident if the call light (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	did not reach. In interview with the Administrator on 06/04/2025 at 6:02 PM, she stated that she would educate residents to ask for a staff member to be present (if the call light did not reach). She said she would investigate the issue further.