

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/10/2026
NAME OF PROVIDER OR SUPPLIER  Nhc Healthcare, Glasgow		STREET ADDRESS, CITY, STATE, ZIP CODE  109 Homewood Boulevard Glasgow, KY 42141	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>Based on observation, interview, record review, and review of facility policy, the facility failed to provide a safe, clean, comfortable, and homelike environment inside the facility for its residents. The findings include:</p> <p>Review of the facility policy titled, NHC Healthcare Glasgow Environment Policy, dated March 2026, revealed the facility strived to maintain a comfortable, safe environment in the facility. Per review, all partners (staff) worked together to identify maintenance issues that needed to be addressed. Further review revealed maintenance partners had the responsibility to ensure . all areas are free of safety hazards.</p> <p>1. Observation on 03/06/2026 at 2:41 PM, of the hallway to the right of the reception desk, revealed metal wall anchors which had been left exposed, protruding out of the wall approximately two inches at a height of approximately 33 inches off the floor. Continued observation revealed the metal anchors had been left exposed when the handrails were removed to paint the walls. Further observation revealed there were four metal anchors on the right side of the hallway and two on the left side of the hallway.</p> <p>Observation on 03/02/2026 through 03/10/2026, at various times, revealed the residents using the hallway walls, where the exposed metal anchors were, to assist in propelling themselves in their wheelchairs. Further observation revealed ambulatory residents were also using the hallway walls to balance when walking.</p> <p>In interview with the facility's Maintenance staff person, on 03/09/2026 at 3:35 PM, he stated he would re-install the handrail, after the State Survey Agency (SSA) Surveyor brought the exposed metal anchors to his attention. He reported however, he did not see how the exposed metal anchors would be harmful to residents.</p> <p>In interview with the Director of Nursing (DON) on 03/10/2025 at 5:56 PM, she stated the facility provided a safe environment for residents by staff being available to provide care 24 hours a day, seven (7) days a week. She said she was unsure when the handrails had been removed leaving the metal anchors exposed. The DON stated she had not noticed the anchors being exposed prior to the SSA Surveyor bringing it to her attention. She further stated she saw no more safety risk to residents than door handles would be.</p> <p>In interview with the Administrator on 03/10/2026 at 6:40 PM, she stated she made daily rounds throughout the building, along with other leadership and maintenance staff. She said the rail had been removed approximately at the end of the week prior to the SSA's arrival. The Administrator reported the metal anchors protruding from the wall presented no safety issue for residents in her opinion. She (continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>explained the reason the rails had not been replaced in that area already was because the facility was waiting on the new handrails to arrive. The Administrator further stated she saw the exposed metal anchors as similar to door handles, and it was her belief the anchors were smooth.</p> <p>2. Observation of station 2 on 03/04/2026 at 2:31 PM, revealed discolored ceiling tiles, in the dining room, which had stains, hand and fingerprints, and there was an exposed cable wire suspended from the ceiling to the lower outer wall. Continued observation revealed one corner of the ventilation screen door was not completely engaged into the ceiling, and there were hooyer sling pads hung against the wall in the dining area. Further observation revealed there were medication carts left in the dining room, and a rollator walker with a seat was left unlocked in dining area. An additional observation of station 2 on 03/07/2026 at 11:24 AM, revealed the crash cart was obstructed by equipment making it not easily accessible in the event of a medical emergency.</p> <p>Observation from 3/3/2026 through 3/10/2026, at various times, revealed the station 4 restorative dining had two exercise machines, cornhole gaming activity, and a wheelchair scale stored along the perimeter of the dining room. Further observation revealed residents dining with the equipment stored in the room.</p> <p>In interview with the Unit Manager (UM), of station 4, on 03/06/2026 at 2:45 PM, she stated her description of a homelike environment was when staff provided residents with their meal off the trays, interacted with residents, and providing a well-lit environment. She stated she realized the NuStep (recumbent cross trainer) and arm ROM exercise machines could be stored elsewhere out of the dining room. The UM said however, the dining room was used for restorative dining and activities. She further stated the wheelchair scale located in the dining room, was only used by one resident.</p> <p>In interview with Licensed Practical Nurse (LPN (2), on Station 2 on 03/07/2026 at 10:47 AM, she stated she had not observed anything that would raise concerns in the dining room. She said she was unsure if the cable hanging from the ceiling, was a big concern. The LPN explained staff were usually in the dining room when the residents were dining. She stated they did have one resident, who wandered that staff had to monitor. LPN 2 reported the dining room used to be where they stored their wheelchairs; however, had been converted to a dining room after so many residents were wanting to eat in there. She said she could see the ventilation cover being a possible concern and she would contact maintenance to take care of it. The LPN stated the medication carts were usually stored in the dining room area, but were not usually in the dining room when meals were being served, as staff were using them out in the hallway to pass medications. She further stated the hooyer slings hanging on the wall were where they had always stored prior to the room becoming a dining area. LPN 2 additionally said, the wheelchairs were also stored there and had never been moved.</p> <p>In interview with the maintenance staff person on 03/09/2026 at 3:35 PM, he stated he was concerned about the wire suspended from the ceiling in the station 2 resident lounge/ dining area. He said the dirty handprints on the ceiling tiles were due to a technician doing a repair on the sprinklers. The maintenance staff person stated the work order for the sprinklers had been provided to the Life Safety Surveyor. He reported the handrails had been recently removed for painting, and the new handrails had been ordered, but had not arrived yet. The maintenance staff person said he would re-install the previous handrails until the new ones arrived. He explained however, he did not see how the missing handrails would be harmful to the residents, even though, it was brought to his attention the protruding metal support could potentially cause harm. The maintenance staff person stated he was informed of repairs throughout the facility, as each nursing station had a maintenance logbook that was checked periodically throughout the day. He further stated for any emergencies or immediate (continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents were treated with respect and dignity and provided care in a manner and in an environment that promoted maintenance or enhancement of his/her quality of life for one of 31 sampled residents, (Resident (R)14). The findings include: Review of the facility policy titled, Patient Rights Booklet (Section J), revised 09/2024, revealed the facility was to provide residents with privacy to maintain a dignified existence. Per policy review, privacy was to be maintained during toileting, bathing, and other activities of personal hygiene. Record review revealed the facility admitted R14 on 11/11/2022, with diagnoses to include atherosclerotic heart disease, lymphedema, anxiety disorder, and history of other venous thrombosis and embolism. Review of the Quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 12/19/2025, revealed the facility assessed R14 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. In interview with R14, on 03/03/2026 at 3:43 PM, she stated she recalled an incident about two weeks ago when a Certified Nurse Aide (CNA) left her lying on her bed in her room and never returned to assist her with getting dressed, and left her wearing only a brief. She stated she could not identify who the CNA had been, but believed it was a male staff member. R14 further stated she believed she informed a nurse; however, was not certain. In interview with R129 (R14's roommate), on 03/09/2026 at 4:30 PM, she stated she recalled a few weeks ago she had been awakened by a male walking out of their room. She said she turned over and observed R14 lying on her bed without any clothing on. R129 stated she believed R14 had been naked. She further stated she was unable to identify who the male had been; however, thought it was a staff member providing R14 with toileting assistance. In interview with CNA 7, on 03/06/2026 at 10:39 AM, she stated she worked on station 4, which included R14's hallway. She said she worked weekends only, Saturday through Monday at night, 7:00 PM to 11:00 PM. The CNA explained she always checked on her residents when she first arrived for her shift. She reported R14 liked to sleep in only a brief and t-shirt or gowns, with a blanket on. CNA 7 stated she recalled one night a few weeks ago when she arrived at the facility and found R14 with her blanket off; however, could not remember what the resident had on, but she had not been naked. The CNA further stated if R14 had voiced concerns to her (CNA 7) about how she (R14) had been left undressed, she would have taken that information to the nurse. In addition, she said she believed R14's blanket had just fallen off of her. During an additional interview with R14, on 03/10/2026 at 8:35 AM, she stated she remembered the night she had been left lying on her bed wearing only a brief. The resident said even though she had no blanket at the time, she had not been naked. She explained she still could not recall the CNA who had been assisting her that night, but denied the CNA being a male. R14 reported she had not liked being left wearing only a brief and she had been very cold. She stated she had not seen the CNA in her room anymore, and later that evening, CNA 7 had arrived for her shift, and assisted her into her night clothes and provided her with a blanket. In interview with CNA14, on 03/10/2026 at 8:45 AM, she stated when R14 pressed the call light for assistance with toileting the staff were to use a sit-to-stand chair with two staff members present. She said call lights were to be answered timely and if they were not then R14 might have potential concerns with infections, skin issues, and constipation. CNA 14 explained R14 preferred to sleep in a brief and gown or sometimes a t-shirt. She stated she had not worked the evening of the incident, so she had not been aware of a concern with R14 having been left wearing only a brief on her bed. CNA 14 further stated the staff on the 3:00 PM to 11:00 PM shift generally helped R14 to bed. In interview with CNA15, on 03/10/2026 at 9:00 AM, she stated she worked on R14's hall and often assisted the resident with toileting. She said she observed R14 lying on her bed wearing only a brief and her blanket lying on the floor. The CNA explained she had reported that information to Licensed Practical Nurse (LPN) 13. She reported the incident had occurred about two weeks ago and had only (continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>happened that once that she was aware of. She further stated she was certain that would be a dignity concern for R14, and could affect the resident psychosocially. A telephonic (phone) interview was attempted with LPN 13, on 03/10/2026 at 4:20 PM; however, was unsuccessful. In interview with the Director of Nursing (DON), on 03/10/2026 at 6:07 PM, she stated one staff person could use the sit-to-stand chair to assist a resident with toileting. She said if staff were assisting a resident with their activities of daily living (ADLs), such as getting them dressed after toileting, her expectation was for the staff member to meet all the resident's needs before leaving the room. In interview with the Administrator, on 03/10/2026 at 6:47 PM, she stated her expectations for resident care was for staff to provide adequate privacy when assisting residents. She further stated she also expected staff to maintain the dignity of the resident in all circumstances.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, record review, and facility policy review, the facility failed to comply with the requirements to inform and provide written information to all residents concerning the right to, at the resident's option, formulate an advance directive for 1 of 31 sampled residents (Resident (R)113). The findings include: Review of the facility policy Do Not Resuscitate (DNR) Order, revised March 2012, showed the interdisciplinary care planning team was to review advance directives with residents during quarterly care planning sessions to see if any changes were desired. Review of R113's Face Sheet showed admission on [DATE] with diagnoses of hemiplegia and hemiparesis post-cerebral infarction on the left non-dominant side. The 01/20/2026 Quarterly Minimum Data Set (MDS) Assessment noted a BIMS score of 15/15, indicating intact cognition. The last quarterly care conference on 02/09/2026 showed no documentation that advance directives were discussed. In an interview on 03/05/2026 at 9:00 AM, the Social Services Director (SSD) stated that advance directives were addressed upon admission, but she was unsure about follow-up timing or documentation for R113 during quarterly care planning. During an interview on 03/05/2026 at 9:30 AM, the admission Coordinator stated that admission paperwork asked about advance directives, but was unsure of follow-up procedures. If residents or families had questions, they were given state legal aid contact information, and advance directive documents were attached to the medical chart if provided. During an interview with R113 on 03/05/2026 at 4:14 PM, the resident stated he did not remember the facility addressing advance directives upon admission or any follow-up afterward. He added that his brother knew his preferences, and he wanted to appoint him as his power of attorney (POA). During the interview on 03/10/2026 at 5:55 PM, the Director of Nursing (DON) stated the Social Services staff had not initially understood advance directives, and she was unfamiliar with when directives were to be revisited. She said she would need to check with Social Services to confirm the timing and could not recall if directives had been discussed in care plan meetings she attended or when she last participated in one. During an interview with the Administrator on 03/10/2026 at 6:37 PM, she stated that advance directives were reviewed at admission, but had not been discussed in care planning meetings she attended. She expected copies of legal documents to be provided at the earliest opportunity.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview, and review of the facility's policy, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, which had the potential to affect 155 of the facility's 155 residents who consumed food from the kitchen. The findings include: Review of the facility policy titled, Dry Storage, revised 06/2025, revealed food items stored in the original packaging and had been opened, were to be closed securely to protect the product. Per review, all items were to be checked at the time of delivery and any severely dented cans or damaged products were to be returned. Continued review revealed questionable dented cans were to be placed in a designated area for thorough review soon after delivery. Additionally, any non-Time/Temperature Controlled for Food Safety (TCS) food product was to be stored in a clean and dry location; not exposed to splash, dust, or other contamination. Review of the facility policy titled, Refrigerator and Freezer Storage, revised 06/2025, revealed food containers were to be clearly labeled with their contents and with the use-by date and/or the date opened. Further review revealed leftover foods were to be stored in an approved container, covered, labeled, and dated and stored in the refrigerator or freezer at the correct temperature. Observation during the initial tour of the kitchen on 03/03/2026, revealed the following: a. Observation of the kitchen's dry pantry storage at 4:00 PM, revealed the #10 can storage shelf had five (120 ounce (oz) cans of apple pie filling, and two (120 oz cans) of mushroom stems and pieces that were dented and damaged, but were still in rotation to serve residents. Continued observation revealed graham cracker crumbs stored on the shelf in a box with the flaps and plastic packaging inside unsealed and exposed to air. Further observation revealed a (97 oz) canister of hot chocolate, opened and undated. In interview with the Food Service Director (FSD) on 03/03/2026 at 4:20 PM, she stated all dented cans were to be stored in her office until they were returned to the food supplier and credited or replaced. She said she had missed the damaged cans that were stored on the active rotation shelf. The FSD reported she had been told by the health department if cans only had dented rims, they were still usable. She further stated she believed the whole box of the apple pie filling cans must have been received at the facility damaged. The FSD additionally said however, she was aware any dented cans should never have been placed in rotation for use. b. Observation of the kitchen's 3-door refrigerator at 4:40 PM, revealed a large, unsealed plastic container of leftover tomato soup exposed to air. 2. During additional tour of the kitchen on 03/04/2026 revealed the following: a. Observation of the 3-door refrigerator at 11:10 AM, revealed the individual rubber seal around the perimeter of the three doors had a dark colored substance in multiple areas. In interview with the FSD, on 03/04/2026 at 11:20 AM, she stated she was aware of the dark colored substance on the 3-door refrigerator seals. She reported however, she and another dietary partner cleaned the inside and outside of the refrigerators weekly with a product containing bleach. The FSD explained even after cleaning with the bleach cleaner the discoloration remained. She further stated she should have reported the issue to maintenance in order to have the seals replaced as there was no way to know what caused the discoloration. b. Observation of two large storage bins in the kitchen at 11:40 AM, revealed one labeled flour and one labeled sugar were located in between the 3-door refrigerator and a staff accessible sink. Continued observation revealed large white pipes entering and exiting the wall above where the two storage bins were kept. Further observation revealed the storage bin that contained flour was located next to the sink and had dried liquid droplets on the lid near the opening of the bin. In an additional interview with the FSD, on 03/04/2026 at 11:50 AM, she stated she was not aware the location of the flour and sugar storage bins was a concern, but after observing the soiled top of the flour bin she said she was aware of the potential for contamination. She further stated space was limited in the kitchen for storage bins that size; however, she would ensure they were moved immediately. In interview with the Administrator, on 03/10/2026 at 6:44 PM, she stated her (continued on next page)</p>		

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