

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Glenview Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 Glenview Drive 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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview, record review, and review of the facility's policy, the facility failed to report allegations of abuse to the State Agencies for two (2) of 13 sampled residents, (Resident (R)8, and R9). The findings include: Review of the facility's policy titled Abuse, Neglect, and Exploitation, reviewed 06/2025, revealed the facility was required to report all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. Further policy review revealed the results of all investigations were to be reported to the appropriate state agency within 5 working days of the alleged violation's initial report. 1. Review of R8's Face Sheet revealed the facility admitted the resident on 11/07/2016 with diagnoses which included unspecified dementia with other behavioral disturbance, bipolar disorder, and hyperlipidemia. Review of R8's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 11/27/2025, revealed the facility assessed R8 as having a Brief Interview for Mental Status (BIMS) score of one (1) out of 15, indicating the resident had severe cognitive impairment. Review of the document titled Event Report, dated 06/13/2025, revealed an event description of Late entry 06/12/2025-1630 Assisted to floor due to behaviors. Further review of the document revealed the location of the fall was in the bathroom with CNA3 being a witness of the fall and there were no injuries related to the fall. Review of Progress Notes, dated 06/13/2025 through 06/15/2025, revealed that on 06/13/2025 the resident was complaining of pain in his right hand and wrist and received an x-ray. Further review of the progress notes revealed that on 06/15/2025 it was documented that the resident was up in wheelchair interacting with staff and complaining of pain to his right hand and fingers and a bruise was noted to his right index finger that appeared to be healing related to recent fall. During an interview with R8 on 01/30/2026 at 11:20 AM, he stated that he is paralyzed on his left side from a gunshot wound to the brain. He stated that he recalled the incident when a staff member pushed him out of his wheelchair onto the bathroom floor. He stated it happened a few months back but was unable to remember the staff member's name. R8 stated the staff member was a black guy. He stated that he didn't do anything wrong and the staff member pushed him out of his wheelchair onto the bathroom floor and told him, I am going to put your ass back in bed and when he picked him up off the floor, he bent his arm back and hurt his hand and wrist. R8 stated he couldn't if he had any bruises or injuries from the incident. He further stated he told every single one of the nurses about it and the staff member no longer comes in his room. During an interview with Licensed Practical Nurse (LPN)2 on 02/01/2026 at 1:28 PM, she stated that she has worked at this facility over a year on nightshift. She stated that she heard about the incident with R8, but she was not working that night. She stated that she remembered people saying that R8 threw himself on the floor and that CNA3 went in there and told him he was not going to pick him up and for him to get up on his own and that he hurt his hand. LPN2 further stated she didn't think</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 185271	If continuation sheet Page 1 of 10

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>it was ever investigated and the Director of Nursing (DON) and Administrator knew about it. During an interview with CNA3 on 02/02/2026 at 9:57 AM, he stated he recalled an incident involving R8, but he could not remember what date. He stated that he has been working at the facility for almost two years. CNA3 stated that he remembered that R8 had a care plan to be lowered to the floor and he was on the toilet. He stated that he and a trainee went in to get him off the toilet and could not lift him up, so they lowered him to the floor. He stated that he told the resident that they were going to come back in a few minutes to help him get up and he returned to assist the resident up and put him back to bed. CNA3 stated that R8 was laughing and joking at that time. He stated that the aides usually work on rotating sides of the building, and he had not been back to work on that side. CNA3 stated that he was not told that he could not work with R8 anymore and thought he had been suspended on the same day that the incident allegedly occurred. He further stated that the facility put him off work pending the investigation and he talked to the Administrator and the DON about it at the time and they told him that he could come back to work. CNA3 stated he was unaware of any injury to R8's hand and the resident did not complain of any pain. During an interview with CNA6 on 02/03/2026 at 8:53 AM, she stated that she was working on the day of 06/12/2025 and she had only been working at the facility for about 4 or 5 days. She stated that she was in orientation and was training with CNA3 on 06/12/2025. She stated that CNA3 was really mean to residents. She stated that anytime R8 would get agitated, CNA3 would put him in the floor. She stated that on that day, she walked into the resident's room and CNA3 was screaming at R8 and CNA3 was threatening to put him in the floor, and she stated that he put him in the floor in the bathroom. CNA6 stated that she told CNA3 that it was not appropriate treatment, and he walked out of the room. She stated that at that time, she and another orientee picked R8 up off the floor and put him back in bed. She stated that she told the DON at that time and the DON quit that same day. During an interview with the former DON on 02/03/2026 at 12:18 PM, she stated that she worked at this facility as the DON from December of 2024 to June of 2025. She stated that she remembered R8 and CNA3. She stated that she did not remember anyone reporting an allegation of abuse to R8. The former DON stated that when she was the DON, she expected all staff to report any allegations of abuse. She further stated that she and the Administrator would have been responsible for investigating and reporting incidents of alleged abuse. During an interview with the former Social Services Director (SSD) on 02/04/2026 at 9:00 AM, she stated that she was employed at the facility for a little over a year from October 15th, 2024, through January 9th, 2026. She stated that she remembered the incident involving R8 very well. She stated that R8 told her that CNA3 put him in the floor and threw him in the bed and hurt his wrist. The former SSD stated that she told the DON at the time and the Administrator. She stated that in a morning meeting after that, they stated that after the investigation it was determined that R8 lowered himself to the floor. She stated that CNA3 has been accused multiple times of hurting residents and that is one of the reasons why she quit her job because the allegations were not being investigated and were being swept under the rug. She stated that when an allegation of abuse was made, whoever heard about it should tell their superior and they would notify the Administrator. The former SSD stated that the entire administrative team would do an investigation after an allegation was made. She stated the admin team would be made up of the Assistant Director of Nursing (ADON), DON, the Administrator, and Social Services. She further stated she would do a questionnaire on residents with a BIMS of 8 or higher and nursing staff would do skin assessments on all the residents with a BIMS of 8 or below. She stated that anyone who knows about an allegation of abuse was supposed to report it to superiors, and the Administrator should report it to the Office of Inspector General. 2. Review of R9's Face Sheet revealed the</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>facility admitted the resident on 06/27/2022 with diagnoses which included Alzheimer's Disease, unspecified hearing loss, and a history of falling. Review of R9's Quarterly MDS Assessment with and ARD of 11/12/2025, revealed the facility assessed R9 as having a BIMS score of nine (9) out of 15, indicating the resident had moderate cognitive impairment. Review of Progress Notes and Skin Assessments dated August of 2025 through October of 2025 revealed no documentation of a bruise or discoloration on the resident's eyes. During an interview with CNA1 on 01/30/2026 at 1:00 PM, she stated that she worked nightshift and has been employed for over a year. She stated that in September of last year, she had just come back to work after having shoulder surgery and R9 had a black eye. She stated that R9 told CNA2 and herself that CNA3 hit her in the eye. She stated that dayshift that day told her about it and that it had been reported to the DON and Administrator. CNA1 stated she could not remember the exact day or month. She stated Human Resources (HR) told her to stay out of it and that it was being taken care of. During an interview with R9 on 01/30/2026 at 2:15 PM, she stated that a black guy hit her in her left eye a few months ago. She stated that she does not know his name. R9 stated that it was on purpose, and he hit her with the back of his hand and caused a big bruise. She stated he could be mean one day and friendly the next day. R9 stated that she was told two female staff members that were sitting at her table, and she did not know who they were. She did not know who they told about it. She stated that no one came to ask her questions about it because she thinks they don't want to talk about it, and they don't want anyone to get in trouble. During an interview with LPN2 on 02/01/2026 at 1:28 PM, she stated that she has worked at this facility over a year on nightshift. She stated that for the incident involving R9, she was there that night. She stated that she was working with CNA8 and CNA3. She stated that she was at the nurse's station, and she heard a curdling scream and went to check, and she stated that she saw CNA3 coming out of a room down that hallway, but she could not tell if he was coming out of R9's room. She stated that the DON was also working that night and came down to the other end of the hall and CNA3 came back up the hall and went into R9's room and the resident was screaming that CNA3 hit her in the eye. She stated that the DON and she went in to talk to the resident and she was rubbing her left eye, and it was starting to bruise at that time. She stated that the DON told her to chart that her eye was bruised because she had been rubbing her eye. She stated that she told the DON that she was not going to chart such a thing and for her to chart it, however, she did not check to see if the DON documented anything. She stated that incident was not investigated, and she knows the abuse policy states that incidents of alleged abuse need to be reported to OIG. During an interview with CNA3 on 02/02/2026 at 9:57 AM, he stated he did not know how the incident happened involving R9. He stated that he did not remember the date of the incident, but it was sometime around September of last year. He stated that he had been in her room giving her milk and then went to use the bathroom and he heard her scream. He stated that he normally does not take care of her very much because she only wants women caregivers and two at a time and he usually just saw her in passing. He stated that he does not know when she accused him of hitting her in the eye and nothing was ever said to him about it. He stated at that time he went back to take care of his residents. He stated that he never saw her eye bruised because he just saw her in passing. During an interview with LPN3 on 02/02/2026 at 11:39 AM, she stated that she remembered R9 having a bruise on her eye and was told that she had been scratching her eye a lot and she heard that R9 accused CNA3 of hitting her in the eye. She stated that she did not remember who told her and that the incident occurred a few months back. She stated that she had abuse and neglect prevention training when she first started working here and more training on SNF Clinic, but she does not know how often she takes the course. During an interview with CNA2 on 02/03/2026 at 2:19 PM, she stated</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>that a few months ago R9 had a black eye, but the incident happened on her night off. She stated that when she came back to work, R9 told her that CNA3 hit her in the eye with his ring. She stated that she reported it to the ADON, and she told her they were aware and that R9 had been rubbing her eye a lot. She stated that everything that ever happened had been told to them that it had been investigated and it never was. During an interview with the former social services director on 02/04/2026 at 9:00 AM, she stated that she worked here for a little over a year from October 15th, 2024, through January 9th, 2026. She stated that she remembered R9 having a bruise on her eye/cheekbone and R9 told her that CNA3 hit her in the eye, but after the investigation, the DON told her that R9 had just been rubbing her eye, so she did not think anything else of it and was told it had been investigated. During an interview with the DON on 02/04/2026 at 10:47 AM, she stated that she has been the DON since June 7th, 2025. She stated that no one has reported anything to her about the incidents involving R8 and R9. She stated that if someone reported something to her, she would have reported it to the Administrator. The DON stated she was aware that abuse was supposed to be reported within two hours. She stated that no one reported any of this to her about any of these incidents. Anytime abuse is reported, it should be reported to the Administrator because she was the abuse coordinator, then the Administrator would notify the DON to start an investigation. She stated that regional comes in and helps with investigations. She stated that they interview staff, residents that are able to be interviewed, completes skin assessments on residents with a BIMS of 7 or below. She stated that they also interviewed staff members involved that worked that hall the incident occurred on. The DON stated that the staff member would be suspended until the investigation was complete. She stated that if the alleged perpetrator was another resident, we would separate the residents. She stated that her expectation for staff if a resident alleges abuse or abuse is witnessed, they were to notify her or the Administrator immediately. The DON stated that even if a resident with a BIMS of 1 came to her with abuse allegations, she would take the allegations seriously and do an investigation. She stated that the ADON does the education and was responsible for providing abuse training to staff. She stated that staff get abuse training annually, upon hire, and as needed if there are any concerns. She stated that they have a clinical meeting every morning and she lays eyes on all residents every day and she stated that she has a good relationship with all of them. During an interview with the Administrator on 02/04/2026 at 12:00 PM, she stated she has been the Administrator since March of last year. She stated she was never informed of any of the abuse allegations for R8, and R9. She stated that she was the abuse coordinator. The Administrator stated the investigation team was composed of herself, ADON, DON, social services director, activities director, and any other staff there to assist at the time. She stated the process for investigating abuse allegations would start with determining if the staff member were still at the facility, then they would be removed from the resident's care area. They would immediately have the nurse assess the resident for skin issues and pain and would interview the resident. The Administrator stated if at that time, she did not have any concerns, she would call social services or any other manager in the facility, and we would begin a BIMS list and start checking skin and interviews as appropriate per their BIMS. She stated that they would notify legal guardians or family, notify the physician, assess residents for psychosocial issues. She stated that after all that is initiated, I would make my report to appropriate agencies within the 2-hour time frame. She stated that she would protect the residents from further abuse by educating staff and reporting the perpetrator to the abuse registry and disciplinary actions. She stated that she would also do staff interviews. She stated that anyone suspecting alleged abuse is responsible for reporting the allegations to the immediate supervisor, who then reports to the abuse coordinator or</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her directly. She stated that her expectations regarding the timeliness of reporting abuse are to act in the best interest of their residents and report immediately.		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure allegations of abuse were thoroughly investigated to prevent further potential abuse for two (2) of 13 sampled residents, (Residents (R)8 and R9). The findings include:Review of the facility's policy titled Abuse, Neglect, and Exploitation, reviewed 06/2025, revealed an immediate investigation was warranted when suspicion of abuse, neglect, or exploitation, or reports of abuse, neglect, or exploitation occurred. Further review of the policy revealed the facility was to identify and interview all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations, and provide complete and thorough documentation of the investigation. 1.Review of R8's Face Sheet revealed the facility admitted the resident on 11/07/2016 with diagnoses which included unspecified dementia with other behavioral disturbance, bipolar disorder, and hyperlipidemia. Review of R8's Quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 11/27/2025, revealed the facility assessed R8 as having a Brief Interview for Mental Status (BIMS) score of one (1) out of 15, indicating the resident had severe cognitive impairment. Review of the document titled Event Report, dated 06/13/2025, revealed an event description of Late entry 06/12/2025-1630 Assisted to floor due to behaviors. Further review of the document revealed the location of the fall was in the bathroom with CNA3 being a witness of the fall and there were no injuries related to the fall.Review of Progress Notes, dated 06/13/2025 through 06/15/2025, revealed that on 06/13/2025 the resident was complaining of pain in his right hand and wrist and received an x-ray. Further review of the progress notes revealed that on 06/15/2025 it was documented that the resident was up in wheelchair interacting with staff and complaining of pain to his right hand and fingers and a bruise was noted to his right index finger that appeared to be healing related to recent fall.During an interview with R8 on 01/30/2026 at 11:20 AM, he stated that he is paralyzed on his left side from a gunshot wound to the brain. He stated that he recalled the incident when a staff member pushed him out of his wheelchair onto the bathroom floor. He stated it happened a few months back but was unable to remember the staff member's name. R8 stated the staff member was a black guy. He stated that he didn't do anything wrong and the staff member pushed him out of his wheelchair onto the bathroom floor and told him, I am going to put your ass back in bed and when he picked him up off the floor, he bent his arm back and hurt his hand and wrist. R8 stated he couldn't if he had any bruises or injuries from the incident. He further stated he told every single one of the nurses about it and the staff member no longer comes in his room. During an interview with Licensed Practical Nurse (LPN)2 on 02/01/2026 at 1:28 PM, she stated that she has worked at this facility over a year on nightshift. She stated that she heard about the incident with R8, but she was not working that night. She stated that she remembered people saying that R8 threw himself on the floor and that CNA3 went in there and told him he was not going to pick him up and for him to get up on his own and that he hurt his hand. LPN2 further stated she didn't think it was ever investigated and the Director of Nursing (DON) and Administrator knew about it. During an interview with CNA3 on 02/02/2026 at 9:57 AM, he stated he recalled an incident involving R8, but he could not remember what date. He stated that he has been working at the facility for almost two years. CNA3 stated that he remembered that R8 had a care plan to be lowered to the floor and he was on the toilet. He stated that he and a trainee went in to get him off the toilet and could not lift him up, so they lowered him to the floor. He stated that he told the resident that they were going to come back in a few minutes to help him get up and he returned to assist the resident up and put him back to bed. CNA3 stated that R8 was laughing and joking at that time. He stated that the aides usually work on rotating sides of the building, and he had not been back</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>to work on that side. CNA3 stated that he was not told that he could not work with R8 anymore and thought he had been suspended on the same day that the incident allegedly occurred. He further stated that the facility put him off work pending the investigation and he talked to the Administrator and the DON about it at the time and they told him that he could come back to work. CNA3 stated he was unaware of any injury to R8's hand and the resident did not complain of any pain. During an interview with CNA6 on 02/03/2026 at 8:53 AM, she stated that she was working on the day of 06/12/2025 and she had only been working at the facility for about 4 or 5 days. She stated that she was in orientation and was training with CNA3 on 06/12/2025. She stated that CNA3 was really mean to residents. She stated that anytime R8 would get agitated, CNA3 would put him in the floor. She stated that on that day, she walked into the resident's room and CNA3 was screaming at R8 and CNA3 was threatening to put him in the floor, and she stated that he put him in the floor in the bathroom. CNA 6 stated that she told CNA3 that it was not appropriate treatment, and he walked out of the room. She stated that at that time, she and another orientee picked R8 up off the floor and put him back in bed. She stated that she told the DON at that time and the DON quit that same day. During an interview with the former DON on 02/03/2026 at 12:18 PM, she stated that she worked at this facility as the DON from December of 2024 to June of 2025. She stated that she remembered R8 and CNA3. She stated that she did not remember anyone coming to her reporting an allegation of abuse to R8. She stated that when she was the DON, she expected all staff to report any allegations of abuse. She stated that she and the administrator would have been responsible for investigating and reporting incidents of alleged abuse. She stated that she and the administrator were responsible for providing training and/or access to training for the employees. During an interview with CNA2 on 02/03/2026 at 2:19 PM, she stated that she has been employed here for almost two years on nightshift. She stated that the only thing she knows about the incident with R8 is what R8 told her and what she heard. She stated that all staff were talking about it at that time and it was the talk of the town. She stated that R8 told her that CNA3 put him in the floor and bent his hand back. She stated that it was told to her when it happened that it had been reported to the DON. She stated that she did not remember if it was the current DON or the former DON. She stated that she has had abuse training and in services on preventing and reporting abuse. She stated that she completed these training courses on hire, this last summer, and this past weekend. She stated that it is everyone's responsibility for reporting abuse. She states that CNA's report it to the nurses, and the nurses report it to the DON and admin. She stated that abuse is to be reported immediately. During an interview with the former Social Services Director (SSD) on 02/04/2026 at 9:00 AM, she stated that she was employed at the facility for a little over a year from October 15th, 2024, through January 9th, 2026. She stated that she remembered the incident involving R8 very well. She stated that R8 told her that CNA3 put him in the floor and threw him in the bed and hurt his wrist. The former SSD stated that she told the DON at the time and the Administrator. She stated that in a morning meeting after that, they stated that after the investigation it was determined that R8 lowered himself to the floor. She stated that CNA3 has been accused multiple times of hurting residents and that is one of the reasons why she quit her job because the allegations were not being investigated and were being swept under the rug. She stated that when an allegation of abuse was made, whoever heard about it should tell their superior and they would notify the Administrator. The former SSD stated that the entire administrative team would do an investigation after an allegation was made. She stated the admin team would be made up of the Assistant Director of Nursing (ADON), DON, the Administrator, and Social Services. She further stated she would do a questionnaire on residents with a BIMS of 8 or higher and nursing staff would do skin assessments on all the</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>residents with a BIMS of 8 or below. She stated that anyone who knows about an allegation of abuse was supposed to report it to superiors, and the Administrator should report it to the Office of Inspector General. 2. Review of R9's Face Sheet revealed the facility admitted the resident on 06/27/2022 with diagnoses which included Alzheimer's Disease, unspecified hearing loss, history of falling, and muscle weakness. Review of the Quarterly MDS Assessment with and ARD of 11/12/2025 revealed the facility assessed R9 as having a BIMS score of nine (9) out of 15, indicating the resident had moderate cognitive impairment. Review of Progress Notes and Skin Assessments from August of 2025 through October of 2025 revealed no documentation of a bruise or discoloration on the resident's eyes. During an interview with CNA1 on 01/30/2026 at 1:00 PM, she stated that she worked nightshift and has been employed for over a year. She stated that in September of last year, she had just come back to work after having shoulder surgery and R9 had a black eye. She stated that R9 told CNA2 and herself that CNA3 hit her in the eye. She stated that dayshift that day told her about it and that it had been reported to the DON and Administrator. CNA1 stated she could not remember the exact day or month. She stated Human Resources (HR) told her to stay out of it and that it was being taken care of. During an interview with R9 on 01/30/2026 at 2:15 PM, she stated that a black guy hit her in her left eye a few months ago. She stated that she does not know his name. R9 stated that it was on purpose, and he hit her with the back of his hand and caused a big bruise. She stated he could be mean one day and friendly the next day. R9 stated that she was told two female staff members that were sitting at her table, and she did not know who they were. She did not know who they told about it. She stated that no one came to ask her questions about it because she thinks they don't want to talk about it, and they don't want anyone to get in trouble. During an interview with LPN2 on 02/01/2026 at 1:28 PM, she stated that she has worked at this facility over a year on nightshift. She stated that for the incident involving R9, she was there that night. She stated that she was working with CNA8 and CNA3. She stated that she was at the nurse's station, and she heard a curdling scream and went to check, and she stated that she saw CNA3 coming out of a room down that hallway, but she could not tell if he was coming out of R9's room. She stated that the DON was also working that night and came down to the other end of the hall and CNA3 came back up the hall and went into R9's room and the resident was screaming that CNA3 hit her in the eye. She stated that the DON and she went in to talk to the resident and she was rubbing her left eye, and it was starting to bruise at that time. She stated that the DON told her to chart that her eye was bruised because she had been rubbing her eye. She stated that she told the DON that she was not going to chart such a thing and for her to chart it, however, she did not check to see if the DON documented anything. She stated that incident was not investigated, and she knows the abuse policy states that incidents of alleged abuse need to be reported to OIG. During an interview with CNA3 on 02/02/2026 at 9:57 AM, he stated he did not know how the incident happened involving R9. He stated that he did not remember the date of the incident, but it was sometime around September of last year. CNA3 stated that he normally does not take care of R9 very much because she only wants women caregivers and two at a time. He stated he usually just saw her in passing. He stated that he does not know when she accused him of hitting her in the eye and nothing was ever said to him about it. CNA3 further stated that he never saw her eye bruised because he just saw her in passing. During an interview with LPN3 on 02/02/2026 at 11:39 AM, she stated that she remembered R9 having a bruise on her eye and was told that she had been scratching her eye a lot. She stated she had heard that R9 accused CNA3 of hitting her in the eye. She stated that she did not remember who told her and that the incident occurred a few months back. During an interview with CNA2 on 02/03/2026 at 2:19 PM, she stated that a few months ago R9 had a black eye, but the incident</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185271	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Glenview Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 Glenview Drive 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.			
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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>happened on her night off. She stated that when she came back to work, R9 told her that CNA3 hit her in the eye with his ring. CNA2 stated that she reported it to the ADON, and she told her they were aware and that R9 had been rubbing her eye a lot. CNA2 further stated that everything that ever happened had been reported to them that it had been investigated and it never was. During an interview with the former Social Services Director (SSD) on 02/04/2026 at 9:00 AM, she stated that she worked at the facility for a little over a year from October 15th, 2024, through January 9th, 2026. She stated that she remembered R9 having a bruise on her eye/cheekbone and R9 told her that CNA3 hit her in the eye. She stated but after the investigation, the DON told her that R9 had just been rubbing her eye, so she did not think anything else of it and was told it had been investigated. During an interview with the DON on 02/04/2026 at 10:47 AM, she stated that she has been the DON since June 7th, 2025. She stated that no one has reported anything to her about the incidents involving R8 and R9. She stated that if someone reported something to her, she would have reported it to the Administrator. The DON stated she was aware that abuse was supposed to be reported within two hours. She stated that no one reported any of this to her about any of these incidents. Anytime abuse is reported, it should be reported to the Administrator because she was the abuse coordinator, then the Administrator would notify the DON to start an investigation. She stated that regional comes in and helps with investigations. She stated that they interview staff, residents that are able to be interviewed, completes skin assessments on residents with a BIMS of 7 or below. She stated that they also interviewed staff members involved that worked that hall the incident occurred on. The DON stated that the staff member would be suspended until the investigation was complete. She stated that if the alleged perpetrator was another resident, we would separate the residents. She stated that her expectation for staff if a resident alleges abuse or abuse is witnessed, they were to notify her or the Administrator immediately. The DON stated that even if a resident with a BIMS of 1 came to her with abuse allegations, she would take the allegations seriously and do an investigation. She stated that the ADON does the education and was responsible for providing abuse training to staff. She stated that staff get abuse training annually, upon hire, and as needed if there are any concerns. She stated that they have a clinical meeting every morning and she lays eyes on all residents every day and she stated that she has a good relationship with all of them. During an interview with the Administrator on 02/04/2026 at 12:00 PM, she stated she has been the Administrator since March of last year. She stated she was never informed of any of the abuse allegations for R8, and R9. She stated that she was the abuse coordinator. The Administrator stated the investigation team was composed of herself, ADON, DON, social services director, activities director, and any other staff there to assist at the time. She stated the process for investigating abuse allegations would start with determining if the staff member were still at the facility, then they would be removed from the resident's care area. They would immediately have the nurse assess the resident for skin issues and pain and would interview the resident. The Administrator stated if at that time, she did not have any concerns, she would call social services or any other manager in the facility, and we would begin a BIMS list and start checking skin and interviews as appropriate per their BIMS. She stated that they would notify legal guardians or family, notify the physician, assess residents for psychosocial issues. She stated that after all that is initiated, I would make my report to appropriate agencies within the 2-hour time frame. She stated that she would protect the residents from further abuse by educating staff and reporting the perpetrator to the abuse registry and disciplinary actions. She stated that she would also do staff interviews. She stated that anyone suspecting alleged abuse is responsible for reporting the allegations to the immediate supervisor, who then reports to the abuse coordinator or her directly. She</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>stated that her expectations regarding the timeliness of reporting abuse are to act in the best interest of their residents and report immediately.</p>		