DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		185093	B. WING			12/	01/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 109 HOMEWOOD BLVD. GLASGOW, KY 42141	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BI HE APPROPRI <i>A</i>		(X5) COMPLETION DATE
F 000	conducted on 12/01/2 to be in compliance w Control and has imple Medicare & Medicaid Centers for Disease ((CDC) recommended	I infection control survey was 2020. The facility was found with 42 CFR 483.80 Infection emented the Centers for Services (CMS) and Control and Prevention I practices to prepare for ent practice was identified.	F	DEFICIENC	Y)		
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u> E	TITLE			(X6) DATE

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.

Facility ID: 100015

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		185093	B. WING			12/	01/2020
NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, GLASGOW				1	STREET ADDRESS, CITY, STATE, ZIP CODE 109 HOMEWOOD BLVD. GLASGOW, KY 42141		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Initial Comments A COVID-19 focused survey was conducted facility was found to b CFR 483.73 Emerger		TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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Facility ID: 100015

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Office of Inspector General

NAME OF PROVIDER OR SUPPLIER NHC HEALTHCARE, GLASGOW SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCY SUMMARY S	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
NHC HEALTHCARE, GLASGOW 109 HOMEWOOD BLVD. GLASGOW, KY 42141 (X4) ID PREFIX TAG N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 12/01/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.			100015	B. WING		12/01/2020
NHC HEALTHCARE, GLASGOW GLASGOW, KY 42141 (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) N 000 Initial Comments A COVID-19 focused infection control survey was conducted on 12/01/2020. The facility was found to be in compliance pursuant to 42 CFR 483.80.	NAME OF PI	ROVIDER OR SUPPLIER				
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		A COVID-19 focused conducted on 12/01/2 to be in compliance p	020. The facility was found ursuant to 42 CFR 483.80.			

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