STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185118	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Elizabethtown	1850 Veteran's Way Elizabethtown, KY 42701

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility policy, the facility failed to report alleged violations involving abuse, neglect, mistreatment, or any reasonable suspicion of a crime, as required, to state agencies for 1 of 10 sample residents, Resident (R)1. (Refer to F760)The findings include:Review of the facility's policy titled, Abuse, Neglect and Misappropriation of Property revised 09/15/2023, revealed the Reporting Guidelines noted, Any abuse allegation must be reported to the State within two hours. Any reasonable suspicion of a crime with serious bodily injury must be reported to the State and Police. Per the policy, suspected crime is defined in the Elder Justice Act, and according to congress.gov, is a reasonable suspicion of a crime.Closed record review of R1's Face Sheet revealed the facility admitted the resident on 09/30/2022, with diagnoses of chronic obstructive pulmonary disease (COPD), chronic pain and osteoarthritis.Review of R1's Resident Progress Notes, dated 03/12/2026 at 2:17 AM, revealed early that morning, R1 was placed on hospice care, per family request. Review of R1's Progress Notes, dated 03/12/2026 at 7:03 AM, revealed Licensed Practical Nurse (LPN)1 documented the following, ARNP gave order Morphine concentrate .25ml q (every) 1hr (one hour) for pain.Review of the Physician Order Report, revealed a new order from the facility Nurse Practitioner (NP) was entered on 03/12/2026 at 7:03 AM for R1. This new order written by Licensed Practical Nurse (LPN)1, revealed orders for 20 milligrams (mg)/5 milliliters (ml) of oral Morphine Solution, administer 0.25 ml (equal to 1mg) to be given as needed for pain. Review of R1's [Hospice Name] Health Nursing Home Visit Record, revealed a verbal order from the Hospice Nurse, dated 03/12/2026 (not timed), to start Morphine 20 mg/5ml, take 1.25 ml (equal to 5mg) every hour or as needed, to be given as needed for pain and dyspnea. Review of R1's Controlled Drug Record Individual Patient's Narcotic Record as well as observation of a photograph of R1's bottle of Morphine on 03/19/2026 at 11:57 AM, revealed the medication delivered for R1's use on 03/12/2026 was oral Morphine Sulfate 100 mg/5 ml Concentrate, with directions to give 0.25 ml (equal to 5 mg), by mouth every hour as needed, as per facility Nurse Practitioner's written order to pharmacy. Additional review of this same record revealed it was stamped to indicate Directions changed. Refer to chart. Further review revealed the oral Morphine Concentrate was administered to R1 on 03/12/2026 at 11:30 AM at .25 ml; 1:46 PM at 1.25 ml; 3:11 PM at 1.25 ml; and 4:49 PM at 1.25 ml by Certified Medication Technician (CMT)3.Record review revealed on 03/12/2026, R1 was administered five times the ordered dose of Morphine, (a schedule II opioid analgesic used to treat severe pain, which had the potential to affect/decrease respiration) on three separate occasions.Review of R1's Resident Progress Notes, revealed the resident was pronounced dead on 03/12/2026 at 5:53 PM.Review of the facility document Stakeholder Suspension Form, CMT3 was placed on suspension and was not available for interview. The State Survey Agency (SSA) attempted to reach CMT3 unsuccessfully on 03/22/2026 by telephone.During an interview with a Detective from the local Police Department, on 03/17/2026 at 12:55 PM, he stated his initial response to the facility was because dispatch stated the facility was not cooperative with the coroner. The detective stated a Hospice Nurse had an issue, alleging there was shredding of paperwork, although he could not (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	substantiate that. The Detective stated HN2 had pictures of R1's medication due to concern of an overdose. The Detective further stated when he responded to the facility on [DATE] at 8:00 PM, the coroner and funeral home representative were already at the facility. He stated the police double checked all R1's medications, retrieved the Morphine and took it into custody. The Detective also stated there was a recorded phone call from the facility Unit Manager (UM), calling hospice to verify milligrams of liquid Morphine, figuring out there was an issue for R1, stating three doses of Morphine were given at five times the ordered amount.In an interview with the facility Nurse Practitioner (NP), on 03/17/2026 at 9:26 AM, she stated the morning of 03/12/2026, she (NP) gave Licensed Practical Nurse (LPN)1 a verbal telephone order to administer 0.25 ml of Morphine Concentrate, and when hospice arrived, they would assume care. Further, the NP stated LPN1 called her back on 03/12/2026 at approximately 6:30 AM to clarify the Morphine order and the NP restated the order to be Morphine Concentrate, which was 100 mg/5 ml, (not 20 mg/5ml as LPN1 documented), give 0.25 ml every hour or as needed. The NP explained she also placed a written order to pharmacy for oral Morphine Concentrate 100 mg/5 ml at 0.25 ml to equal 5 mg, every hour or as needed.In an interview with LPN1, on 03/18/2026 at 9:35 AM, she stated, on 03/12/2026, the NP gave verbal orders which included, Morphine Concentrate at 0.25 ml every hour as needed. LPN1 stated once she got into the computer to place the order of 0.25 ml of Morphine, there were several Morphine options available to choose from and as a result, LPN1 called the NP back to clarify the order. LPN1 stated the NP then clarified the order as Morphine 20 mg/5ml.During an interview with Hospice Nurse (HN)1, on 03/18/2026 at 1:19 PM, she stated she wrote on a paper document, labeled Nursing Home Visit Record, the new order to increase the Morphine Solution to 1.25 ml to equal 5 mg as needed, per physician's order. In further interview with HN1, she stated the new order to increase the Morphine was based on the Physician Order Report, which showed 20 mg/5 ml, and she did not see the facility NP's written order to the pharmacy or the label on the bottle of Morphine, (which both indicated 100 mg/5 ml).In an interview with the Unit Manager (UM), on 03/17/2026 at approximately 10:30 AM, she stated on 03/12/2026 at 12:00 PM, when Hospice Nurse (HN)1 gave the hand-written order to increase the Morphine to 1.25ml equal 5 mg, she brought her concern to the Assistant Director of Nursing (ADON) because she had not seen an order for 1.25 ml before. She explained, later in the shift, (and documented by hospice at 5:10 PM), she called hospice to question the order and faxed them requested documents. Further, she stated she left for the day prior to receiving clarification as to the accuracy of the order. The UM further stated LPN2 called her, stating she could not locate R1's Morphine narcotic sheet (Controlled Drug Record Individual Patient's Narcotic Record) and HN2 wanted to review it. The UM stated when she returned to the facility, she noted the coroner and the police were at the facility.During an interview with the ADON, on 03/17/2026 at 11:23 AM, she confirmed that on 03/12/2026, she instructed the UM to call hospice for clarification due to her concerns about the order when the Morphine was increased due to how it was written, as well as the amount of 1.25 ml because the amount seemed like a lot to her. The ADON stated she was unaware the UM did not contact hospice for order clarification until 5:10 PM, shortly before R1's death. The ADON further stated, after leaving the facility, she received a call to return to the facility because HN2 had some concerns about the amount of Morphine that was administered to R1 prior to her death. The ADON stated she came back to the facility, and the police were there. The ADON further stated she only knew police were investigating whatever HN2 told them, and she assumed it was hospice that called the police, but she was not sure. In an interview with HN2, on 03/18/2026 at 12:34 PM, she stated when she asked facility staff to see the paperwork the previous hospice nurse (HN1) left, she was told the paper was shredded. HN2 also asked to see R1's Morphine narcotic log (Controlled Drug Record Individual Patient's Narcotic Record) and the facility staff were unable to locate the log. She stated the facility had already called a funeral home to pick up R1's remains. HN2 stated when she received the Morphine narcotic log she took pictures of R1's bottle of Morphine (with the label showing a dose concentration of 100 mg/5 ml rather than 20 mg/ml). HN2 stated she gave a brief (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	history of what happened to the coroner, who called the police.The SSA surveyor attempted to contact the coroner on 03/18/2026 at 9:37AM and was unsuccessful. Additionally, a formal records request was sent on 03/16/2026 at 10:39 AM. In an interview with the Director of Nursing (DON), on 03/22/2026 at 1:56 PM, she stated alleged violations or incidents that should be reported to the Office of Inspector General (OIG) would be any type of abuse. The DON stated these allegations should be brought to the Administrator because she processed the report. When asked if the incident regarding R1 should have been reported by the facility to the state agencies, the DON replied, As far as I know, it was reported by police.In an interview with the Facility Administrator, on 03/22/2026 at 2:25 PM, she stated alleged violations or incidents that should be reported to the OIG/state agencies include abuse, neglect, misappropriation, fire, and any type of harm. She stated she or the DON could report the alleged violations. The Administrator confirmed she did not report allegations regarding R1 to the state agencies because she knew the police were going to report the incident. She stated the police said they were going to report the allegation. In an interview with the facility Medical Director, on 03/22/2026 at 2:06 PM, he stated reporting alleged violations or incidents to the SSA was not his area of expertise and he was not sure of the specifics. However, when asked if the incident regarding R1 should have been reported, he stated, Yes, probably so.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, record review, and review of facility policy, the facility failed to ensure residents were free of significant medication errors for 1 of 10 sampled residents reviewed for narcotic administration, Resident (R)1. On 03/12/2026, R1 was administered 5 times the intended dose of Morphine (a schedule II opioid analgesic used to treat severe pain and misuse of the medicine can cause addition, overdose, or death) on three separate instances. R1 was pronounced dead on 03/12/2026 at 5:53 PM. The facility's failure to have an effective system to ensure residents were free from significant medication errors was likely to cause serious injury, impairment, or death to a resident. On 03/20/2026 Immediate Jeopardy was identified and determined to exist on 03/12/2026 in the area of 42 CFR 483.45, Pharmacy Services (F760) at a Scope and Severity of a J. Substandard Quality of Care (SQC) was identified.The facility provided an acceptable Immediate Jeopardy (IJ) Removal Plan on 03/21/2026, alleging removal of the IJ on 03/22/2026. The State Survey Agency (SSA) validated IJ was removed on 03/22/2026, prior to exit, which lowered the S/S to a D while the facility develops and implements a Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors to ensure compliance with systemic changesRefer to F609The findings include: Review of the facility's policy titled, Medication Administration, dated 01/2024, last revised 06/2025, revealed, If a dose seems inappropriate or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification.Review of the facility's policy titled, Physician's Orders, dated 06/2025, last revised 01/2026, revealed Licensed Nurses are expected to notify the physician with any concerns related to new physician orders or potential need for changes in orders.Review of the facility's policy titled, Medications Ordering and Receiving From Pharmacy Provider, 3.7 Medication and Medication Labels, dated 01/2025 revealed, If a prescriber's directions for use change or the label is inaccurate, the nurse may place a direction change, change of order-check chart or similar label on the container indicating there is a change in directions for use, taking care not to cover important label information.When such a direction change label appears on the container, the medication nurse checks the resident's medication administration record (MAR) or the prescriber's order for current information.If directions for use change, the provider pharmacy is informed prior to the next refill of the prescription so the new container will show the accurate label.Closed record review of R1's Face Sheet revealed the facility admitted the resident on 09/30/2022, with diagnoses including chronic obstructive pulmonary disease (COPD), chronic pain and osteoarthritis. On 10/24/2025, R1 was placed on palliative care for chronic pain and COPD.Review of the quarterly Minimum Data Set (MDS), dated 12/22/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of fifteen out of fifteen indicating intact cognition.Review of R1's Comprehensive Care Plan revealed a problem of change in condition: oxygen saturation, blood pressure and heart rate fluctuations with problem start date 03/10/2026. Goal: Resolve without complications. Approaches: Diagnostics as ordered; labs as ordered, medications as ordered, monitor for changes and report as needed, and oxygen as ordered. (All approaches dated 03/10/2026).Further review of R1's Comprehensive Care Plan revealed a problem of requires use of oxygen with a problem start date 03/10/2026. Goal: The resident will have no adverse outcomes related to oxygen saturation through next review. Approaches included: elevate head of bed as needed for shortness of breath; labs as ordered; medication as ordered; notify physician with changes as needed; observe for signs and symptoms of respiratory distress; and, oxygen as ordered. (All approaches dated 03/10/2026).Continued review of R1's Comprehensive Care Plan revealed a problem of being at risk for pain: complains of right hip, pelvic, knees and back pain. Edited 03/12/2026. Goal: Resident will have relief or reduction in pain intensity within 1 hour after receiving interventions through the review date. Approaches included: administer pain medications per physicians orders (09/30/2022); complete (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	pain screen on admission and as needed (PRN) (09/30/2022); observe effectiveness of pain medication (09/30/2022); provide comfort measures (09/30/2022); consult with pain management (10/26/2022); report to physician if resident does not experience reduction or relief of pain after one hour of receiving prescribed interventions (10/10/2023), medications and treatment per order (10/10/2023) and x-rays as ordered (10/21/2025).Review of R1's Resident Progress Notes, dated 03/11/2026, revealed R1 was diagnosed with pneumonia and had a significant health decline, as evidenced by decreased oxygenation saturation, shallow breathing, and lethargy. The Resident Progress Notes, dated 03/12/2026 at 2:17 AM, revealed early that morning, R1 was placed on hospice care, per family request. Review of R1's Physician Order Report, revealed a new order from the facility Nurse Practitioner (NP) was entered on 03/12/2026 at 7:03 AM. The new order written by Licensed Practical Nurse (LPN)1, revealed orders for 20 milligrams (mg)/5 milliliters (ml) of oral Morphine Solution, administer 0.25 ml (this was equal to 1mg).Review of the [Hosparus] Health Nursing Home Visit Record, revealed a verbal order from the Hospice Nurse, dated 03/12/2026 (not timed), to start Morphine 20 mg/5ml, take 1.25 ml every hour or as needed (this was an equivalent to 5mg).Review of R1's medical record revealed that the verbal orders given to LPN1 by the Nurse Practitioner and the Hospice Nurse were documented in the Medication Administration Record (MAR) to be 20 mg/5 ml of Morphine; however, the dosage of the two medications were different as one was an equivalent of 1mg of liquid Morphine while the other was an equivalent of 5mg. Further review revealed the medication that was delivered by pharmacy had a different concentration at 100mg/5ml with directions to administer .25 ml (which was an equivalent to 5mg and the intended dosage to administer to the resident).Review of the Controlled Drug Record Individual Patient's Narcotic Record as well as observation of a photograph of R1's bottle of Morphine on 03/19/2026 at 11:57 AM, revealed the medication delivered for R1's use was oral Morphine Sulfate 100 mg/5 ml Concentrate, with directions to give 0.25 ml equal to 5 mg, by mouth every hour as needed as per facility Nurse Practitioner's written order to pharmacy. Further review of this same record revealed it was stamped to indicate Directions changed. Refer to chart. Continued review revealed the oral Morphine Concentrate was administered to R1 on 03/12/2026 at 11:30 AM at .25 ml; 1:46 PM at 1.25 ml (this was an equivalent to 25mg); 3:11 PM at 1.25 ml; and 4:49 PM at 1.25 ml. Further review revealed CMT3 documented that she had administered the medication.Further closed record review of R1's Resident Progress Notes, revealed R1 was pronounced dead on 03/12/2026 at 5:53 PM.Per review of facility document Stakeholder Suspension Form, revealed CMT3 was placed on suspension and was not available for interview. Review of CMT3's statement, documented on 03/12/2026, revealed, I always observe the five rights to ensure I am giving the correct medication. Per the statement, after CMT3 gave the first dose of Morphine (.25), HN1 observed R1's response and then increased the order to 1.25 ml, using the order listing on the electronic MAR. CMT3 documented she double checked with HN1 the dose of 1.25 ml because she had never given that much before and HN1 stated it was correct.The State Survey Agency (SSA) surveyor attempted a telephonic interview with CMT3, on 03/22/2026 at 12:11 PM. This attempt, however, was unsuccessful and CMT3 did not return the surveyor's call.During an interview with LPN1, on 03/18/2026 at 9:35 AM, she stated, at the beginning of her shift on 03/12/2026 she was assessing R1, and the resident would hardly wake up. LPN1 stated the resident had pneumonia and decreased respirations. Further, LPN1 explained the family stated they wanted hospice on the morning of 03/12/2026, and she (LPN1) notified hospice and the facility NP. In further interview, LPN1 stated she informed the NP that hospice would not arrive until later, and the NP gave verbal orders which included, Morphine Concentrate at 0.25 ml every hour as needed. LPN1 stated once she got into the computer to place the order of 0.25 ml of Morphine, she thought it would automatically populate. However, several Morphine options were available to choose from and as a result, LPN1 called the NP back to clarify the order. LPN1 stated the NP gave an order for Morphine 20 mg/5ml. LPN1 stated she had ordered these medications on the computer before and did not have any concerns about the orders she had placed on 03/12/2026. During an interview with (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the facility Nurse Practitioner (NP), on 03/17/2026 at 9:26 AM, she stated the family made the decision to place R1 on hospice on the morning of 03/12/2026, after the resident had a health decline beginning earlier that week, was not responding as usual, became lethargic, and was diagnosed with pneumonia. The NP stated the morning of 03/12/2026, she (NP) gave LPN1 a verbal telephone order to give 0.25 ml of Morphine Concentrate, and when hospice arrived, they would assume care. The NP further stated LPN1 called her back on 03/12/2026 at approximately 6:30 AM to clarify the Morphine order and the NP restated the order to be Morphine Concentrate, which was 100 mg/5 ml, (not 20 mg/5ml as LPN1 documented), give 0.25 ml every hour or as needed. According to the NP, she then also placed a written order to pharmacy for oral Morphine Concentrate 100 mg/5 ml at 0.25 ml to equal 5 mg, every hour or as needed. The NP stated this was a common order for residents receiving end of life care. During an interview with the facility's Pharmacy Representative, on 03/17/2026 at 11:57 AM, he stated providers placed medication orders at their own discretion. He stated the pharmacy sent and dispensed medication based on what the provider prescribed. He explained, on 03/12/2026, the facility NP sent in an order for 100 mg/5 ml Morphine Concentrate. He stated the prescription request was sent at 6:56 AM, and the Morphine left the pharmacy at 8:08 AM and was received by the facility at 11:02 AM. He further stated the pharmacy did not fill scripts without a provider's order. The Pharmacy Representative stated it was up to the facility staff to ensure the correct order matched the correct medication prior to administering medication.During an interview with LPN2, on 03/18/2026 at 1:08 PM, she stated she was the nurse who received R1's medications on 03/12/2026 from pharmacy. She stated, We must sign for them, log them in the control binder. I compared the bottle of liquid Morphine to the actual order from pharmacy and looked at the computer and did not see any differences [between the bottle which showed 100 mg/5 ml vs the order in the electronic health record which showed 20 mg/5ml].During continued interview with LPN2, on 03/18/2026 at 1:08 PM, she stated she was unaware the orders in the electronic medical record (EMR) which were used for medication administration, and the labeled dose on the bottle of Morphine Concentrate, did not match until later that day when she called pharmacy to get a stat (immediate) order of another bottle of liquid Morphine. She stated she called pharmacy because she did not want to run out of medication as CMT3 had already given three doses of liquid Morphine at 1.25ml.During further interview with LPN2, on 03/18/2026 at 1:08 PM, she stated when the pharmacy inquired about the need for another bottle so soon, she mentioned the increased dose. The pharmacy responded, the dose was supposed to be 0.25 ml not 1.25 ml. LPN2 stated after she got off the phone with pharmacy, she notified the Unit Manager. LPN2 stated she did not believe there had been a medication error because the hospice nurse gave the order; however, she did not identify the increase in the hospice order was made based on the documentation on the Physician's Order Report (which showed 20 mg/5 ml, rather than the 100 mg/5 ml which was what was actually ordered, delivered to the facility, and administered to R1). During an interview with Hospice Nurse (HN)1, on 03/18/2026 at 1:19 PM, she stated she arrived at the facility on 03/12/2026 before 11:00 AM. HN1 stated the facility had ordered Morphine on their own prior to her arrival, but the medication had not yet arrived, and R1 was showing a lot of discomfort. HN1 explained, after speaking with the family, she (HN1) came out of R1's room and noted the Morphine had arrived, and staff were preparing to administer the first dose. HN1 stated she looked at the MAR and saw an order for Morphine Solution, 20 mg at 5 ml, give .25ml, which would equal 1mg. HN1 stated she observed CMT3 administer the first dose of Morphine to R1, who continued to show signs of discomfort. In response, HN1 stated she spoke with the hospice physician, who gave an order to increase the Morphine Solution to 5 mg.During continued interview with HN1, on 03/18/2026 at 1:19 PM, she stated she wrote on a paper document, labeled Nursing Home Visit Record, the new order to increase the Morphine Solution to 1.25 ml to equal 5 mg as needed, per physician's order. In further interview with HN1, she stated the new order to increase the Morphine was based on the Physician Order Report, which showed 20 mg/5 ml, and she did not see the facility NP's written order to the pharmacy or the label on the bottle of Morphine, (which both indicated 100 (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	mg/5 ml).During an interview with the Unit Manager (UM), on 03/17/2026 at approximately 10:30 AM, she started on 03/12/2026 at 12:00 PM, when HN1 gave the hand-written order to increase the Morphine to 1.25ml to equal 5 mg, the Morphine order bothered her. The UM stated she brought her concern to the Assistant Director of Nursing (ADON) because she had not seen an order for 1.25 ml before. She further stated, later in the shift, she called hospice to question the order and faxed them requested documents. The UM stated after receipt of the fax confirmation, R1 passed away.During continued interview with the UM, on 03/17/2026 at approximately 10:30 AM, she stated she left for the day prior to receiving clarification as to the accuracy of the order. The UM stated after she left for the day, LPN2 called her, stating she could not locate R1's Morphine narcotic sheet (Controlled Drug Record Individual Patient's Narcotic Record) and HN2 wanted to review it. The UM stated upon arrival back to the facility, she located R1's Morphine narcotic sheet in front of the narcotic book and noted the coroner and the police were at the facility, which was not typical. She stated at this point, the Director of Nursing (DON) and Administrator removed CMT3 and did not allow her to complete the rest of her shift. In further interview with the UM, she stated CMTs received ongoing training in medication administration including the five rights of medication administration, as well as the process of receiving medications from suppliers. Per the UM, the five rights of medication administration which include verifying the right dose, apply to all staff that administer medication. During an interview with the ADON, on 03/17/2026 at 11:23 AM, she stated that on 03/12/2026, she instructed the UM to call hospice for clarification due to her concerns about the 12:42 order when the Morphine was increased due to how it was written, as well as the amount of 1.25 ml because the amount seemed like a lot to her. The ADON stated she was unaware the UM did not contact hospice for order clarification until 5:10 PM, shortly before R1's death. The ADON further stated, after leaving the facility, she received a call to return to the facility because HN2 had some concerns. During an interview with HN2, on 03/18/2026 at 12:34 PM, she stated on 03/12/2026, she received a call at approximately 5:30 PM to go to the facility. Per HN2, hospice customer support had received phone calls from the facility and had questions regarding doses of Morphine that were administered to R1. HN2 stated by the time she arrived at the facility, R1 had passed away. HN2 stated she notified hospice and was instructed to assess the situation, based on instructions from their legal team. HN2 stated she and the funeral home representative contacted the coroner and explained the situation. HN2 stated while there, she reviewed the Morphine narcotic log (Controlled Drug Record Individual Patient's Narcotic Record) and took pictures of R1's bottle of Morphine (with the label showing a dose concentration of 100 mg/5 ml rather than 20 mg/ml). HN2 stated she gave a brief history of what happened to the coroner, who called the police, and she left the facility. During an interview with the Police Department Detective, on 03/17/2026 at 12:55 PM, he stated he initially came to the facility because dispatch had stated the facility was not cooperative with the coroner, who had been called in after R1's death. The Detective stated HN2 took pictures of R1's medication over the concern of an overdose. He further stated the police retrieved and checked R1's Morphine and took the bottle into custody. The Detective stated law enforcement had custody of the medication. Observation of the police photographs confirmed that R1's Morphine label read 100 mg/5 ml in 18 ml bottle, with 14 ml of the concentrate remaining. The detective also stated there were recorded phone calls from facility staff calling hospice to verify milligrams of oral liquid Morphine and identifying there was an issue with a medication error for R1 with three doses of Morphine given at five times the ordered concentration.The SSA surveyor attempted to contact the coroner by phone on 03/18/2026 at 9:37AM and was unsuccessful, as he was out of town. A formal records request was sent on 03/16/2026 at 10:39 AM. Interviews with Registered Nurse (RN)1, on 03/17/2026 at 7:31 AM, RN2 on 03/17/2026 at 9:43 AM, and RN6 on 03/17/2026 at 9:51 AM, all revealed prior to administering medications, the person administering the medication should visually observe the medication container and compare it with both the computer order and narcotic sheet (if applicable). They stated if any of the information did not match, staff should immediately contact the provider or pharmacy for clarification.During an interview with the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185118	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Elizabethtown	1850 Veteran's Way Elizabethtown, KY 42701

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Registered Pharmacist (RPh), on 03/20/2026 at 8:34 AM, he stated when medications were delivered to the facility by pharmacy, a manifest was provided, and staff should verify that the medication the pharmacy delivered matched the manifest form and staff should sign to ensure correctness. However, the RPh stated, the medication that was delivered and the manifest form did not have anything to do with the medication order in the facility's computer EMR. The pharmacist stated, based on the concentration/bottle of Morphine delivered to the facility, R1 received 25 mg of Morphine (rather than 5 mg) on three separate administrations in approximately three hours. He stated this was five times the ordered dose in each administration. In further interview with the RPh, he stated this medication error could cause a resident to experience shortness of breath and sedation that could lead to death. During interview with the facility Director of Nursing (DON), on 03/22/2026 at 1:56 PM, she stated it was her expectation prior to medication administration, that staff would check the drug in hand and compare it to the computer order in the EMR. The DON stated, staff was to perform the five rights for medication administration, and if something did not match, the nurse or nurse supervisor was to be notified. She stated the five rights for medication administration included right patient, right drug, right dose, right route, and right time, and staff should follow this to prevent a medication error. The DON further stated when R1's Morphine order came into question; staff should have brought their concerns to the provider who ordered the medication and the Unit Manager. She stated there could be the risk of a medication error if staff failed to reach out to the pharmacy or the provider when there was a question about a medication dose.During an interview with the facility Medical Director, on 03/22/2026 at 2:06 PM, he explained it was his expectation for staff to reconcile medications prior to administration by looking at the medication and comparing it to the order in the computer. He stated it was his expectation staff would perform the five rights of medication administration prior to administering any medication. He further stated if the medication labels did not match the order, staff should contact the provider who wrote the order and clarify. The Medical Director further stated if there was a concern regarding a medication order, staff should clarify with the provider or the pharmacy. He stated staff should not continue with the administration of a medication if there was a concern with the medication order. During an interview with the facility Administrator, on 03/22/2026 at 2:25PM, she stated it was her expectation that prior to medication administration, staff would follow the five rights. The Administrator stated staff should check the bottle or package against the MAR and ensure they matched the resident, medication dose, and medication route. The Administrator added, if the CMT had a medication concern, they should go to their charge nurse, and if it was a nurse with a concern, they should directly contact the provider. She stated there was the risk of a medication error if staff failed to perform the five rights prior to medication administration. The Administrator stated when R1's Morphine order came into question; staff should have contacted the facility provider. She further stated there was the risk of a medication error if staff did not reach out to the pharmacy or the provider when there were questions about a medication order.