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	02/13/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview, record review, facility document review, and facility policy review, the facility failed to notify the Nurse Practitioner (NP), Medical Director (MD) and management staff when the administration of an immediate (STAT, statim) order for medication was delayed due to not being received from the pharmacy timely. This failure affected 1 (Resident #105) of 1 resident reviewed for notifications. The findings included: A facility policy titled, Physicians Orders, revised 01/30/2026, indicated, 3. Licensed Nurses are expected to notify the physician with any concerns related to new physician orders or potential need for changes in orders. A Resident Face Sheet indicated the facility admitted Resident #105 on 12/06/2025. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of chronic pain syndrome. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12 2025, revealed Resident #105 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident had received scheduled pain medication but had not received PRN pain medications or was offered and declined during the assessment's five-day lookback period. Resident #105's Care Plan, included a problem statement dated 12/08/2025, that indicated the resident had complaints of pain related to Parkinson's radiculopathy, chronic pain syndrome, and a left wrist fracture. Interventions directed staff to administer pain medication as ordered (initiated 02/07/2026). During a concurrent interview and observation on 02/09/2026 at 11:21 AM, Resident #105 was observed to have an elastic bandage wrapped around their left hand/wrist area. Resident #105 stated that they had a fall on Saturday (02/07/2026) when they went to the bathroom without assistance and fell on their way back to their bed. Resident #105 stated since the fall their pain had been tolerable because staff had provided them with medication, ice/hot compress, and elevate their hand and now they are waiting on their ortho appointment to be scheduled. Resident #105's Resident Progress Notes, dated 02/07/2026 at 9:34 AM, revealed the resident had an unwitnessed fall while attempting to ambulate to the bathroom. The notes revealed the resident reported pain in their left wrist. The notes revealed that the provider was notified. Resident #105's Resident Progress Notes, dated 02/07/2026 at 2:27 PM, revealed a new order was received for x-rays to the resident's left wrist. The notes revealed the resident had received Tylenol for pain and discomfort that was somewhat effective. Resident #105's Resident Progress Notes, dated 02/07/2026 at 6:57 PM, revealed the x-ray results indicated the resident had a left wrist fracture. Per the notes, the provider was notified of the x-ray results and that the resident's pain was not resolved. The notes revealed that the staff were waiting for the provider's response. Resident #105's Resident Progress Notes, dated 02/07/2026 at 8:35 PM, revealed a new order for tramadol 50 milligrams (mg) by mouth every six hours as needed (pro re nata, PRN) for pain related to the resident's left wrist fracture was received.Resident #105's Resident Progress Notes, dated 02/08/2026 at 4:09 AM, revealed the resident received PRN Tylenol around 1:09 AM for left wrist pain with some relief noted. The notes revealed Licensed Practical Nurse (LPN) # 2 inquired two times around 11:30 PM (on 02/07/2026) and again around 4:00 AM (on 02/08/2026) as to when the delivery of tramadol would arrive since the medication had been ordered STAT (statim, immediate). Per the notes, a pharmacy technician (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
	185118	A. Building B. Wing	02/13/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that the pharmacy had many requests for STAT orders and there was only one delivery driver on the weekend. The notes revealed staff were told that the medication was enroute to the facility. Resident #105's Resident Progress Notes, dated 02/08/2026 at 7:01 AM, revealed the resident received PRN tramadol for left wrist pain around 5:19 AM and it appeared to be more effective than Tylenol alone. A pharmacy Shipping Manifest, dated 02/07/2026, revealed a STAT order for tramadol 50 mg was ordered for Resident #105 and was received by the facility on 02/08/2026 at 5:14 AM. Resident #105's Medication Administration Record [MAR] for the timeframe from 02/01/2026 through 02/09/2026 revealed staff documented that the resident received tramadol 50 mg on 02/08/2026 at 5:19 AM. During a telephone interview on 02/10/2026 at 6:16 PM, LPN #2 stated she called the pharmacy twice to get an update on the delivery of the STAT tramadol order and was told by a pharmacy technician that they only had one delivery driver. She stated that the tramadol was received on 02/08/2026 at 4:19 AM. LPN #2 stated she did not notify the MD or NP of the delay of the medication (tramadol). During an interview on 02/11/2026 at 10:22 AM, the NP stated she sent a STAT order for tramadol for Resident #105 on 02/07/2026 at approximately 9:00 PM and had not been notified of the delay. The NP stated staff should have notified her of any delay in receiving the tramadol order for Resident #105. During a telephone interview on 02/11/2026 at 1:51 PM, LPN #3 stated he spoke to the NP, and the NP ordered a STAT order for tramadol (on 02/07/2026). LPN #3 stated he then called the pharmacy to confirm the STAT order for the tramadol had been received. LPN #3 stated he had no further involvement in this incident.During a telephone interview on 02/11/2026 at 3:01 PM, the MD stated he had not been notified of the delay in receiving the tramadol for Resident #105. During an interview on 02/12/2026 at 10:06 AM, The Director of Nursing (DON) stated she expected the nurse to document and notify management if medications were not received timely. The DON stated that the time for STAT orders should be received within four hours, and she expected the staff to notify the MD and/or NP if there was a delay in receiving medication from the pharmacy. During an interview on 02/12/2026 at 10:27 AM, the Assistant Director of Nursing (ADON) stated she expected staff to notify the MD, NP, and/or management staff if there was a delay in receiving orders from the pharmacy. During a telephone interview on 02/12/2026 at 4:15 PM, the Pharmacy Operations Manager stated the tramadol was ordered STAT on 02/07/2026 at 9:09 PM, and on the weekends they do not have many drivers but that the medication was received by the facility on 02/08/2026 at 5:14 AM. During an interview on 02/13/2026 at 9:30 AM, the Administrator stated she expected the staff to notify the NP, MD, and management staff when there was a delay in receiving any medication from the pharmacy. The Administrator stated she was not aware of the delay in receiving Resident #105's tramadol. The Administrator stated that it was unacceptable that staff did not call the NP or MD when the tramadol was not delivered promptly.