STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185266	A. Building B. Wing	01/31/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabethtown Nursing and Rehabilitation Center	1101 Woodland Drive 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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and review of the facility's Payroll Based Journal Data Report, the facility failed to ensure there was a Registered Nurse (RN) on duty at least 8 consecutivc hours a day, 7 days a week. There was no documented evidence there was a RN working at the facility on 07/12/2025, 07/20/2025, 09/06/2025, and 09/07/2025.The findings include:Review of the document signed by the Administrator, dated 01/29/2026, revealed, The facility does not have a specific policy on staffing.Review of the facility's Payroll Based Journal (PBJ) Data Report, for the timeframe from 07/01/2025 to 09/30/2025, revealed no Registered Nurse (RN) hours were submitted for 07/12/2025, 07/20/2025, 09/06/2025, and 09/07/2025.During an interview, on 01/31/2026 at 9:12 AM, the Payroll Manager stated she submitted the PBJ hours for all the facility's employees. The Payroll Manager stated there were four days in the previous quarter when she could not record any RN hours because there was not an RN available to work a shift during those days. The Payroll Manager further stated, the Director of Nursing (DON) at the time may have worked those days on an on-call basis, but she did not submit those hours as RN coverage to the PBJ reporting because being available on an on-call basis was already part of the DON's job description.During an interview, on 01/31/2026 at 9:26 AM, the current DON, who started working at the facility in November 2025, stated there were four weekend days prior to her date of hire where the facility did not have RN coverage per the PBJ report. The DON further stated she expected there to be an RN available to cover the required eight hours, and if there was not an RN available, she would come in and work as an RN on the floor to fulfill the minimum staffing requirement.During an interview, on 01/31/2026 at 9:42 AM, the Administrator stated the previous DON did work at some point during the days in question, but they did not know how to code the hours correctly. The Administrator stated she expected there to be an RN working in the facility eight hours per day, seven days a week, to fulfill the minimum RN requirement. The Administrator further stated it was important to have an RN available because there were some nursing tasks that only an RN could complete in order to provide proper care for the residents.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and review of facility policy, the facility failed to prepare, distribute and serve food in accordance with professional standards for food safety. Observation on 01/30/2026 revealed Cook1 failed to remove soiled gloves and wash hands when appropriate while preparing and serving food. Further, Cook1 failed to use tongs to place bread on the meal trays, and instead handled the bread with his gloved hands.The findings include:Review of the facility policy titled, Food: Preparation, revised 02/2023, revealed, All foods are prepared in accordance with the FDA [Food and Drug Administration] Food Code. Procedures - 1. All staff will practice proper hand-washing techniques and glove use. 2. Dining Service Staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination.Observation on 01/30/2026 at 11:00 AM, revealed while Cook1 blended vegetables, he touched his beard covering with his gloved hands. After touching his beard covering, Cook1 then failed to remove his gloves and wash his hands and continued to prepare the pureed vegetables.Observation on 01/30/2026 beginning at 11:25 AM, revealed Cook1 donned oven mitts over black gloves, pulled a pan of baked fish out of the oven, and removed the oven mitts. Cook1 then failed to wash his hands and don new gloves before pulling serving utensils out of the drawers and placing them on the steam table. While wearing the same soiled gloves, Cook1 then pulled his beard cover up, but failed to remove his soiled gloves and wash his hands before he retrieved serving utensils for the steam table.Further observation during the same meal service, revealed Cook1, while wearing the same soiled gloves, again donned oven mitts before removing a pan of fish from the oven, and then removed the mitts. Cook1 then failed to remove the soiled gloves and wash his hands before placing five servings of fish in a small pan, and placing the fish on the steam table.Additional observation during the same meal service, revealed while wearing the same soiled gloves, Cook1 retrieved a cutting board, and then failed to remove his soiled gloves and wash hands before removing the remaining fish from the tray, placing the fish on the cutting board, and chopping the fish for the mechanical soft diets using a large knife. Once the fish was fully chopped, Cook1 placed the fish in a pan, and placed the pan on the steam table.Continued observation during the same meal service, revealed Cook1 again donned oven mitts over the same pair of soiled gloves, and removed a tray of fish from the oven. While wearing the oven mitts, he tipped the tray to place the fish into a pan to place on the steam table. Cook1 then placed the dirty pan in the dishwashing area, removed his soiled gloves and washed his hands. Continued observation during the same meal service, revealed Cook1 donned new black gloves, opened a loaf of bread, and with his gloved hand placed a slice of bread on each meal tray instead of using tongs to plate the bread. Cook1 touched his beard cover and adjusted his ball cap while plating the bread, but failed to remove his gloves and wash his hands before continuing to plate the bread with his gloved hand.Additional observation during the same meal service, revealed when Cook1 ran out of fish on the steam table, he placed oven mitts over his soiled gloved hands, pulled a tray of fish out of the oven, and removed the fish from the pan. Cook1 then removed his gloves and, without using any soap, rinsed his hands, dried them, donned new gloves, and returned to the steam table to continue the meal service.During an interview, on 01/30/2026 at 1:10 PM, Cook1 stated he should have washed his hands a little more often than he did during the meal service. Cook1 stated he was to wash his hands upon entering the kitchen, anytime he changed gloves, and when there was a risk for cross-contamination. Cook1 further stated he should change gloves anytime he went from one product to another, anytime he touched himself, and anytime he handled food. Further, Cook1 stated he would consider the gloves soiled if they were inside oven mitts. Cook1 stated the oven mitts were washed every other day, but he could see how failing to wash his hands after handling the oven mitts could result in cross-contamination.During an interview, on 01/31/2026 at 9:31 AM, the District Manager stated Cook1 should have used tongs to plate the bread. The District Manager stated he (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	expected staff to immediately change gloves and wash hands when the gloves became soiled.During an interview, on 01/31/2026 at 10:05 AM, the Director of Nursing (DON) stated, if staff was preparing food, once they touched something dirty, they should remove the soiled gloves and wash their hands. The DON further stated staff should wash their hands and change gloves after they touched their face, hair, or person.During an interview, on 01/31/2026 at 10:20 AM, the Administrator stated kitchen staff needed to wash their hands at appropriate time to prevent cross-contamination. She stated kitchen staff should wash their hands after each task. The Administrator further stated kitchen staff should wash hands and change gloves after using the mitts and then proceed with what they were doing with the food.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, record review, and review of facility policy, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This failure had the potential to affect all 59 residents in the building. The facility failed to ensure fit testing for employees. Fit testing refers to a mandatory Occupational Safety and Health Administration (OSHA) regulated procedure that verifies a tight-fitting respirator (such as an N95 mask) properly seals to an employee's face in order to minimize contaminants entering the mask through gaps between the seal and the skin. Additionally, observations on 01/28/2026 and 01/29/2026, revealed staff entered Resident (R)29's room, who was diagnosed with COVID-19, without wearing the appropriate personal protective equipment (PPE). Furthermore, R37, who was R29's roommate, was not tested for COVID-19, after R29 tested positive for COVID-19.The findings include: Review of the facility policy titled, Infection Control, revised October 2018, revealed, This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The policy revealed, . 4. All personnel will be trained on our infection control policies upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control.1. During an interview on 01/30/2026 at 12:18 PM, the Staff Development Coordinator (SDC)/ Infection Preventionist (IP) stated she was unable to find a policy regarding staff fit testing for N95 respirators.Additionally, the facility was unable to provide documented evidence of annual N95 fit testing.During an interview, on 01/30/2026 at 12:08 PM, the SDC/IP stated the facility currently did not have the needed supplies to conduct fit testing for employees, so she visually inspected the mask and seal to ensure proper fit.During an interview, on 01/30/2026 at 10:47 AM, the Director of Nursing (DON) stated she was not aware fit testing had not occurred. She further stated it was her expectation that fit testing for employees be completed upon hire and annually.During an interview, on 01/30/2026 at 10:57 AM, the Administrator stated the last time fit testing was conducted was in 2022. Additionally, she stated after she became aware fit testing had not been done, she ordered all the supplies for the testing, and the facility would conduct fit testing as soon as the supplies arrived.2. a. Review of the facility policy titled, Isolation- Categories of Transmission-Based Precautions, revealed, Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Once initiated, the resident is placed in isolation for the designated time frame, with services provided in the resident room versus communal areas. [sic] (such as nursing care, therapy, dining, activities, etc. [et cetera; and so forth]. The policy revealed, Droplet Precautions included, 1. Droplet Precautions may be implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets that can be generated by the individual coughing, sneezing, talking, or by performance of procedures such as suctioning); . 3. Masks will be worn when entering the room; and 4. Gloves, gown and goggles should be worn if there is risk of spraying respiratory secretions. The policy revealed, Airborne Precautions included, 1. Airborne precautions are indicated when and [sic] individual is infected with a pathogen that is very small and can be transmitted long distances through the air. The policy further revealed, . 4. Any individuals who enter the room of a resident placed on airborne precautions must wear approved respiratory protection.Review of the Centers for Disease Control and Prevention (CDC) guidance titled, Viral Respiratory Pathogens Toolkit for Nursing Homes, revised 01/23/2026, revealed, HCP [healthcare personnel] who enter the room of a resident with signs or symptoms of an unknown respiratory viral infection that is consistent with SARS-CoV-2 [COVID-19] infection should adhere to Standard Precautions and use a NIOSH [National Institute for Occupational (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safety and Health]-approved particulate respirator with N95 filters or higher, gowns, gloves, and eye protection (i.e. [id est; that is], goggles or a face shield that covers the front and sides of the face.Review of R29's admission Face Sheet revealed the facility admitted the resident on 12/22/2025 with a diagnosis of a stroke with residual hemiplegia and hemiparesis (weakness and/or paralysis to one side of the body).Review of R29's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/27/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of 10 out of 15, which indicated moderate cognitive impairment.Review of R29's nursing Misc [Miscellaneous] note, dated 01/21/2026, revealed the resident had been coughing and congested. The note indicated facility staff contacted the Advanced Practice Registered Nurse (APRN) and obtained orders for a respiratory panel to be sent to the laboratory. Per documentation, the specimen was obtained and placed for laboratory staff to pick up. Review of R29's Careplan Report included a problem statement initiated 01/24/2026, that indicated the resident tested positive for COVID-19.Review of R29's nursing Misc note, dated 01/24/2026, revealed the resident's respiratory panel was positive for COVID-19. The note indicated the resident was placed on droplet precautions for five days.Review of R29's Physician's Order Form As Of 01/28/2026 revealed an order dated 01/24/2026 for the resident to be on droplet precautions, with staff instructions to wear a gown and gloves when entering the resident's room.Observation on 01/28/2026 at 9:52 AM, revealed a sign above R29's room placard indicating the resident was on droplet precautions, with instructions that indicated everyone must clean their hands upon entering and leaving the room and ensure their eyes, nose, and mouth were fully covered prior to entry. The sign indicated everyone was to remove face protection before exiting the room. There was a three-drawer plastic storage unit below the signage on the floor with N95 respirators, KN95 respirators, surgical masks, face shields, gowns, and gloves available. There was also a wall unit beside the door placard with gloves and gowns available.Further observation on 01/28/2026 at 9:52 AM, revealed Certified Nurse Aide (CNA)2 donned a gown, a surgical mask, and gloves and entered R29's room, closing the door behind her. CNA2 did not put on a face shield or an N95 respirator prior to entering the room.During an interview, on 01/29/26 at 3:37 PM, CNA2 stated she wore a gown, gloves, and surgical mask, but not a face shield to provide care to R29.Observation on 01/28/2026 at 12:14 PM, revealed CNA3 delivered R29's meal tray and assisted with setting it up. CNA3 wore a gown and gloves. She did not wear any face shield, eye protection, or N95 respirator. The droplet precaution sign was present above the placard, and the storage bin was still present.During an interview, on 01/28/2026 at 12:14 PM, CNA3 stated she did not wear a mask or face shield while delivering and setting up R29's meal.During an interview, on 01/29/2026 at 8:58 AM, the Staff Development Coordinator (SDC)/ Infection Preventionist (IP) stated if a resident tested positive for COVID-19, staff was expected to wear a face shield or goggles, an N95 respirator, gown, and gloves. She stated staff was trained in the use of personal protective equipment (PPE) and she expected staff to know when to wear it.During an interview, on 01/30/2026 at 2:43 PM, the Director of Nursing (DON) stated she expected staff to follow the pictures on the signage and don the appropriate PPE. She stated using an N95 respirator and following the rest of the pictures on the signage for R29, was the same as abiding by airborne precautions.During an interview on 01/30/2026 at 3:27 PM, the Administrator stated it was her expectation the facility staff follow CDC guidance for transmission-based precautions.2. b. Review of the CDC guidance titled, Infection Control Guidance: SARS-CoV-2, dated 06/24/2025, revealed, Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.Review of R37's admission Face Sheet revealed the facility admitted the resident on 01/02/2026. R37 was R29's roommate.Review of R37's admission MDS, with an ARD of 01/07/2026, revealed the R37 had an active diagnosis of a right (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	femur (thigh bone) fracture. The MDS further indicated the facility assessed the resident as having a BIMS score of 12 out of 15, which indicated moderate cognitive impairment.The facility was unable to provide documented evidence of a COVID-19 test for R37 after R29 tested positive.During an interview, on 01/30/2026 at 10:42 AM, the SDC/IP stated she believed R37 was tested for COVID-19 with one of the facility's rapid tests.During an interview, on 01/30/2026 at 2:43 PM, the DON stated the facility staff tested R37 on day one with negative result or symptoms. She stated R37's symptoms had improved after testing on day 1. She further stated she expected the residents to be tested for COVID-19 according to CDC guidance.During an interview, on 01/30/2026 at 12:37 PM, the Advanced Practice Nurse Practitioner (APRN) stated she expected the facility staff to follow CDC guidance related to COVID-19 testing.During an interview, on 01/30/2026 at 3:27 PM, the Administrator stated she expected the facility staff to have completed testing on R37 per the CDC guidance.