STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185400	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elkton Nursing and Rehabilitation Center	506 Allensville Road Elkton, KY 42220

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and review of facility policy, the facility failed to ensure residents had the right to receive services in the facility with reasonable accommodations of resident needs and preferences for 7 out of 15 sampled residents, Resident (R)8, R9, R30, R32, R33, R36, and R49. R32 and R36 complained call lights were not answered timely. Additionally, observations on 07/22/2024, and 07/24/2025, revealed R8, R9, R30, R33, and R49's call light was out of reach, and inaccessible to the residents.Review of the facility policy titled, Resident Rights, undated, revealed the resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Review of the facility policy titled, Placement of Call Light and Answering Call Light, undated, revealed the call light should be plugged in at all times, and when a resident is in bed or confined to a chair the call light shall be within reach of the resident. Further review of the policy revealed all defective call lights should be reported to the nurse supervisor promptly; and answer the resident's call light immediately. Review of the facility document titled, In-Service Training Report, dated 05/28/2025, revealed all call lights must be answered immediately by any available staff even if you are not assigned to that room or section. 1. Review of R32's Face Sheet located in the Electronic Medical Record (EMR), revealed the facility admitted the resident on 01/21/2025 with diagnoses including fibromyalgia, major depressive disorder, gastroesophageal reflux disease without esophagitis, and cough, unspecified. Review of R32's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference date (ARD) of 05/14/2025, revealed the facility assessed R32 as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating intact cognition. Further review revealed R32 was assessed as ambulation not attempted, and as always incontinent of bowel and bladder. Continued review revealed the facility assessed the resident as receiving oxygen therapy. Review of R32's Comprehensive Care Plan, revealed a focus area stating the resident would have no substantiated false accusations/allegations through next assessment date. Date Initiated: 01/27/2025, Revised on: 05/13/2025, Target Date: 08/06/2025. Interventions included: Abuse policy is to be followed with each allegation as indicated; Allow resident to discuss feelings of anger, powerlessness, and frustration as needed; and Allow resident to express thoughts without judgement from facility staff. All interventions were initiated on 01/27/2025 and revised on 04/07/2025. Observation of R32, on 07/22/2025 at 12:34 PM, revealed she was in bed and was receiving oxygen at 3.5 liters per minute per nasal cannula. During an interview with R32, on 07/22/2025 at 12:34 PM, she stated at times her call light went off for over an hour before staff would come to her room to answer it. R32 stated at times staff (could not recall which staff) would just stand outside her room looking at her like she had the plague. She stated she was told by one of the nurses (could not recall which nurse) that most staff were banned from her room. She stated she did not want anyone banned from her room. R32 further stated the nurses on both sides of the building would not enter her room. In further interview with R32, on 07/22/2025 at 12:34 PM, she stated she was having trouble breathing and her oxygen (saturation) was low. She stated staff would not come to her room to help her. R32 stated she begged someone to call the ambulance. She further stated she started screaming to get someone back to her room. R32 stated she felt panicked when staff did not answer her call light timely. During an interview (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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with SRNA3 and SRNA5, on 07/25/2025 at 10:45 AM, they both stated sometimes they would have to go find people that were allowed in R32's room, unless it was an emergency as the resident would only allow certain staff to care for her. They could not recall a specific incident related to staff not answering her call light timely. However, further interview revealed it was important for staff to answer R32's call light quickly in case there was an emergency. During an interview with SRNA2, on 07/25/2025 at 10:50 AM, she stated R32 would only allow a handful of people in her room. Also, there had to be two people minimum to go into her room because of her history of making accusations against staff. However, SRNA2 stated it was important for staff to answer R32's call light quickly to keep her calm. During an interview with Licensed Practical Nurse (LPN)4, on 07/25/2025 11:00 AM, she stated only certain staff were allowed in R32's room, unless it was an emergency. In further interview, she stated R32 would have panic attacks thinking that her oxygen saturations were low, and staff would try to calm her down. However, LPN4 stated it was important for staff to answer R32's call light quickly to keep her from panicking. 2. Review of R36's Face Sheet, revealed the facility admitted the resident on 05/22/2024, with diagnosis including cerebral infarction, hemiplegia affecting left side, dysphagia, and type 2 diabetes. Review of R36's quarterly MDS Assessment, dated 06/28/2025, revealed the facility assessed the resident as having a BIMS score of 15 out of 15, indicating intact cognition. Continued review of the MDS, revealed the facility assessed the resident as requiring substantial/maximal assistance with mobility, dressing, bathing, and toileting. Further, the facility assessed the resident as always incontinent of bowel and bladder. During an interview with R36, on 07/22/2025 at 3:33 PM, she stated one morning before night shift left, staff assisted her up in her wheelchair around 6:20 AM. She stated shortly after, she had a bowel movement while up in the chair. R36 stated she rang the call light which took a long time for an aide to answer, and then the aide told her it was change of shift and she would have to wait for dayshift to assist her. R36 could not recall the date of the incident nor the name of the aide who told her she would have to wait. In further interview, R36 stated it always took forever for her call light to be answered during shift change. She stated most days and nights it took well over an hour for someone to answer her call light. During an interview with SRNA3 and SRNA5, on 07/25/2025 at 10:45 AM, they both stated they were unaware of R36 having to wait for incontinence care or wait a long time for the call light to be answered. During an interview with SRNA2, on 07/25/2025 at 10:50 AM, she stated she could not recall an incident when R36 had a bowel movement in the wheelchair. Per interview, residents should not have to wait a long time for the call lights to be answered or for incontinence care to be provided. During an interview with SRNA6, on 07/25/2025 at 10:55 AM, she stated she could not recall an incident where R36 had to wait a long time for incontinence care; however, stated it was important for staff to answer call lights timely and provide the needed care. 3.Review of R8's Face Sheet, revealed the facility admitted the resident on 03/07/2025 with diagnoses to include Parkinsonism, acute osteomyelitis of the right ankle and foot, and muscle weakness. Review of R8's quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 06/14/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of four out of 15 indicating severe cognitive impairment. Observation of R8 on 07/24/2025 at 3:10 PM, revealed the resident was sitting up in the wheelchair in front of his bedside table and the call light was not in reach. The call light was wrapped around the bed rail which was furthest away from him. 4.Review of R9's Face Sheet, revealed the facility admitted the resident on 10/16/2019 with diagnoses to include unspecified sequelae cerebral infarction, chronic obstructive pulmonary disease, and aphasia following cerebral infarction. Review of R9's quarterly Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 05/27/2025, revealed staff did not perform a Brief Interview for Mental Status (BIMS) as the resident was rarely or never understood. Observation of R9, on 07/22/2025 at 1:23 PM, revealed the call light was on the floor and inaccessible to the resident. 5.Review of R 30's Face Sheet, revealed the facility admitted the resident on 07/10/2017 with diagnoses to include epilepsy, heart failure, and unspecified dementia. Review of R30's quarterly (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 06/14/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 11 out of 15, indicating moderate cognitive impairment. Observation of R30, on 07/24/2025 at 3:20 PM, revealed the resident's call light was tied to his bed and hanging in the floor. R 30 was sitting up in his wheelchair in the middle of his room away from the bed, and the call light was not in reach. 6.Review of R33's Face Sheet, revealed the facility admitted the resident on 07/11/2025 with diagnoses to include cerebral infarction, acute kidney failure, and encounter for palliative care. R 33's MDS Assessment was not completed due to the resident being a recent admission.Observation of R33, on 07/24/2025 at 3:09 PM, 3:30 PM, and 5:15 PM, revealed the resident was lying in bed and the call light was noted to be lying on the floor out of the resident's reach. 7. Review of R49's Face Sheet, revealed the facility admitted the resident on 07/17/2025 with diagnoses to include hyperlipidemia, anxiety disorder, and other specified soft tissue disorder. R49's MDS Assessment was not completed due to the resident being a recent admission. Observation of R49, on 07/24/2025 at 3:01 PM, revealed the resident's call light was noted lying on the floor as the resident was asleep in bed. The call light was out of reach of the resident. In an interview with State Registered Nurse Aide (SRNA) 3, on 07/25/2025 at 11:36 AM, she stated before leaving a resident's room staff was to make sure the call light was in reach. She further stated the call light should not be lying in the floor. In an interview with Licensed Practical Nurse (LPN 3), on 07/25/2025 at 2:37 PM, she stated staff should check for call light placement before leaving the room and make sure it was within reach of the resident. She stated a resident could have a fall or need some kind of assistance and would not be able to call staff for help if the call light was out of reach. In an interview with the Assistant Director of Nursing (ADON), on 07/25/2025 at 1:09 PM, she stated she constantly addressed issues with staff regarding the call lights. She stated call lights would be going off all the time while nursing staff was sitting at the desk and not answering, to the point she would have to go and answer them herself. She stated the facility needed to have in-services for the staff to educate them to answer the call lights immediately and to ensure the call lights were in reach of the resident before leaving the resident's room. Further, she stated she had high expectations for the care the residents at the facility received, and the facility needed to work on the call light issue. In an interview with the Director of Nursing (DON), on 07/25/2025 at 2:43 PM, she stated it was her expectation for all residents' call lights to be within reach of the resident. She stated the call lights should also be answered within a timely manner. She further stated staff had a lot of down time on the night shift so there should be no delay in answering the call lights on that shift. She further stated the facility was going to have to have heavy amounts of in-services to educate staff to answer call lights quickly and to ensure the call light was accessible to the resident. In an interview with the Administrator, on 07/25/2025 at 3:00 PM, he stated it was his expectation for the staff to provide compassionate care to the residents, according to their care plan. He stated it was the staffs' job to meet the needs of the residents. The Administrator further stated he thought call lights were brought up in resident council meeting. However, he stated he was not sure if any education had been presented to staff regarding the call light issue. He stated in the future there would need to be education, training and in-services to bring everyone up to standard regarding call lights. He further stated it was his expectation for call lights to be answered timely. The Administrator stated no staff should walk past a call light without acknowledging it, and if it was a non-clinical staff member who could not take care of the need, they should let the resident know they would be finding someone who could take care of them.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of facility policy, staff failed to ensure a clean, comfortable, and home-like environment. Observations on 07/23/2025, 07/24/2025, and 07/24/2025, revealed the handrails along the hall corridor were filled with food wrappers, and crumbs. Also, there was a Styrofoam cup containing a liquid substance on the handrail by room [ROOM NUMBER].The findings include: Review of facility policy titled, Resident Rights, undated, revealed the resident has a right to a safe, clean, comfortable and homelike environment including but not limited to receiving treatment and supports for daily living safely. Observation on 07/23/2025 at 1:40 PM, 07/24/2025 at 3:21 PM, and 07/24/2025 at 5:32 PM, revealed the handrails along the hall corridor were filled with food wrappers, and crumbs. Continued observation revealed there was a Styrofoam cup containing a liquid substance on the handrail by room [ROOM NUMBER]. In an interview with Housekeeper (HK)1 on 07/25/2025 at 1:49 PM, she stated her primary job responsibilities included maintaining a clean environment for the residents and staff. She stated the facility typically had four to five housekeeping staff members working per shift and sometimes a sixth housekeeper if needed. In further interview, she stated the extra person working in housekeeping on the evening shift would be the one responsible for cleaning the hallway corridors, handrails, and floors. During continued interview with HK1, on 07/25/2025 at 1:49 PM, she stated if she was to see something that needed immediate attention such as a spill on the floor, she would clean it up. She stated even when short staffed, the housekeepers could get the job done. However, she stated it just depended on which housekeepers were working on a particular day, if the job gets done. She stated failure to properly clean could cause cross contamination. HK1 stated if the cup on the handrail had spilled onto the floor, it could have created a fall hazard. Further, she stated the loose items on the handrail could have caused a potential choking hazard if mobile residents came by and put the items in their mouth. In an interview with the Housekeeping Supervisor, on 07/25/2025 at 1:55 PM, she stated it was her expectation for her housekeeping staff to make sure everything was neat and tidy. The Housekeeping Supervisor stated she had an extra housekeeper who was responsible for the halls, doors, lobby, glass, and activities area. She stated this week she did not have that extra person working. However, she stated when she did not have the extra housekeeper, she assigned those specific areas to other housekeepers who were to clean them once the rooms had been cleaned. During further interview with the Housekeeping Supervisor, on 07/25/2025 at 1:55 PM, she stated she tried to go through the facility and make sure she walked the halls and picked up any items that may have been left behind, but she also worked as a State Registered Nurse Aide (SRNA) on the floor. She stated she often would get pulled from her housekeeping duties to work in the capacity of a nurse aide. During further interview with the Housekeeping Supervisor, on 07/25/2025 at 1:55 PM, she stated she used to take a housekeeper's word on whether or not something was cleaned, but she learned things were getting missed so she started having them take the cleaning form with them and sign it once tasks were completed. She stated there could be negative outcomes if a resident picked up some of the items from the handrails and attempted to eat them. She further a resident could have sustained a fall from the liquid if it had spilled. In an interview with the Director of Nursing, on 07 /25/2025 at 2:43 PM, she stated it was her expectation for the facility to be clean and tidy. Further, she stated the facility should be a homelike environment for the residents. In an interview with the Administrator, on 07/25/2025 at 3:00 PM, he stated it was his expectation for the housekeeping staff to keep the common rooms, hallways and patient rooms clean in order to maintain a homelike environment. He stated he walked the facility periodically to ensure housekeeping was being maintained. The Administrator stated if he saw an area the housekeeping staff missed, he would find the Housekeeping Supervisor and discuss what needed to be cleaned. He stated the Housekeeping (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Supervisor also completed audits to ensure the housekeepers were completing work as assigned. The Administrator stated, yesterday, he picked up things from the floor to try and maintain a clean area. He further stated, all staff definitely needed an in-service related to keeping the facility clean and it would take a culture change in order to make this happen. The Administrator stated the facility needed to hold staff accountable for keeping the building clean and tidy, and he was not sure if that was done in the past.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and review of facility policy, the facility failed to store drugs in a manner to preserve integrity.Observation of the medication room refrigerator, revealed 2 COVID-19 vaccine syringes, both expired and 1 of the syringes was shattered.Review of the facility's policy titled Medication Storage, reviewed 03/2025, revealed expired, contaminated, deteriorated medications, and medications in containers that are cracked, soiled, or without secure closures are to be immediately removed from stock and disposed of according to procedures for medication destruction and reordered from the pharmacy if a current order exists. Observation of the medication storage room refrigerator, on 07/23/2025 at 2:55 PM, revealed a plastic bag containing two expired COVID-19 vaccine syringes with an expiration date of 04/24/2025, and one of the syringes was shattered. During an interview with Kentucky Medication Aide (KMA)1, on 07/23/2025 at 3:00 PM, she stated nurses were responsible for checking the medication carts and medication refrigerators for expired medications. She further stated pharmacy representatives usually came once per month and checked for expired medications and vaccines on the carts and in the refrigerators. During an interview with the Director of Nursing (DON), on 07/23/2025 at 3:20 PM, she stated she did not know why expired COVID-19 vaccine syringes were in the medication refrigerator. She stated pharmacy staff was at the facility yesterday and should have removed the expired vaccines. During an interview with the DON, on 07/25/2025 at 2:43 PM, she stated if expired medications including vaccinations were administered to a resident, the resident could have a reaction. She further stated having expired vaccinations in the medication refrigerator was an infection control issue. The DON stated it was her expectation for staff to check the medication room and medication carts and remove expired medications from the medication room and refrigerator stock, and medication carts. During an interview with the facility's Administrator, on 07/25/2025 at 3:21 PM, he stated it was his expectation for nursing staff to provide exceptional care to the residents and provide for every resident's needs. He stated he expected staff to properly store medications and make sure all medications were not expired.