STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185415	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elliott Nursing and Rehabilitation	20 Howards Creek Road Sandy Hook, KY 41171

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview, record review, review of the facility's policy, and review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, the facility failed to accurately code Minimum Data Set (MDS) assessments for 2 of 2 residents reviewed for resident assessment requirements, Resident (R) 1 and R2.The findings include:Review of the facility's policy titled, Accurate Assessment, dated 08/01/2025, revealed the purpose was To assure that all residents/patients receive an accurate assessment, reflective of the resident's/patient's status at the time of the assessment, by the Care Team Members qualified to assess relevant care areas. Further review of the policy revealed definitions to include Accuracy of assessment is the appropriate, qualified health professionals correctly document the resident's/patient's medical, functional, and psychosocial problems and identify resident/patient strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e. [id est; that is] comprehensive, quarterly, significant change in status). Continued review revealed the policy included C. The appropriate, qualified health professional will correctly document the resident's/patient's characteristics, medical, functional, and psychosocial problems and identifies resident/patient strengths to maintain or improve medical status, functional abilities, and psychosocial status.Review of the Centers for Medicare & Medicaid Services [CMS] Long-Term Care Facility Resident Assessment Instrument user manuals, dated 10/2024 and 10/2025, revealed N0415: High-Risk Drug Classes: Use and Indication Coding Instructions included Code all high-risk drug class medications according to their pharmacological classification, not how they are being used. Further review of the manual revealed Column 1: Check if the resident is taking any medications by pharmacological classification during the 7-day observation period (or since admission/entry or reentry if less than 7 days. Continued review of the manual revealed Column 2: If Column 1 is checked, check if there is an indication noted for all medications in the drug class. Review of the manual revealed N0415E1. Anticoagulant (e.g. [exempli gratia; for example], warfarin, heparin, or low molecular weight heparin): Check if an anticoagulant medication was taken by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Further review of the manual revealed N0415E2. Anticoagulant: Check if there is an indication noted for all anticoagulant medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days. Continued review of the manual revealed N0415I1. Antiplatelet: Check if an antiplatelet medication (e.g., aspirin/extended release, dipyridamole, clopidogrel) was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days). Review of the manual revealed N0415I2. Antiplatelet: Check if there is an indication noted for all antiplatelet medications taken by the resident any time during the observation period (or since admission/entry or reentry if less than 7 days). Further review of the manual revealed Coding Tips and Special Populations included Do not code antiplatelet medications such as aspirin/extended release, dipyridamole, or clopidogrel as N0415E, Anticoagulant.Review of R1's admission Record revealed the facility admitted R1 on 10/07/2024 with diagnoses to include hemiplegia (paralysis on one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction (the (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: 185415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	death of brain tissue due to a blockage in blood supply) affecting left-nondominant side.Review of R1's significant change in status MDS, with an Assessment Reference Date (ARD) of 03/11/2026, revealed R1 had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated the resident had moderate cognitive impairment. Further review of the MDS revealed the resident received anticoagulant medication during the seven-day lookback period and the medication was indicated.Review of R1's Care Plan Report included a focus area, initiated 09/05/2024, that revealed the resident was at risk for increased bruising or bleeding due to use of antiplatelet medication. Further review revealed the interventions directed staff to administer medication as ordered. Continued review revealed no indication that the resident received anticoagulant medication.Review of R1's Order Recap [Recapitulation] Report, for the timeframe from 02/01/2026 through 04/30/2026, that included active and discontinued orders, revealed an order dated 03/04/2026 for clopidogrel (an antiplatelet medication) 75 milligrams (mg) one time a day for blood clot prevention. Further review revealed no orders for medications classified as anticoagulants.During an interview with the Registered Nurse Assessment Coordinator (RNAC) on 04/08/2026 at 3:05 PM, she stated R1's significant change in status MDS was inaccurately coded because she thought that clopidogrel was an anticoagulant.2. Review of R50's admission Record revealed the facility admitted R50 on 10/21/2022 with diagnoses to include chronic systolic heart failure.Review of R50's annual MDS, with an ARD of 08/16/2025, revealed R50 had a BIMS score of five out of 15, which indicated the resident had severe cognitive impairment. Further review revealed the resident received anticoagulant medication during the seven-day lookback period and the medication was indicated.Review of R50's quarterly MDS, with an ARD of 11/12/2025, revealed R50 had a BIMS score of five out of 15, which indicated the resident had severe cognitive impairment. Further review revealed the resident received anticoagulant medication during the seven-day lookback period and the medication was indicated.Review of R50's quarterly MDS, with an ARD of 02/05/2026, revealed R50 had a BIMS score of five out of 15, which indicated the resident had severe cognitive impairment. Further review revealed the resident received anticoagulant medication during the seven-day lookback period and the medication was indicated.Review of R50's Care Plan Report revealed no indication that the resident received anticoagulant medication.Review of R50's Order Recap [Recapitulation] Report, for the timeframe from 08/01/2025 through 04/30/2026, which included active and discontinued orders, revealed an active order with an original order date of 05/24/2023 for ticagrelor (an antiplatelet medication) 90 mg two times a day for blood thinner. Further review revealed no orders for medications classified as anticoagulants.During an interview with the RNAC on 04/08/2026 at 3:05 PM, she stated the information for MDS assessments came from the residents' medical records. She stated she reviewed resident orders and MARs [Medical Administration Records] to determine what kinds of medication a resident was on. The RNAC stated R50 was on ticagrelor, which she categorized as an anticoagulant. She stated R50's previous three MDS assessments, including two quarterly assessments and an annual assessment, were inaccurately coded because she thought ticagrelor was an anticoagulant.During an interview with the Director of Nursing (DON) on 04/09/2026 at 1:09 PM, she stated the RNAC was responsible for coding MDS assessments, and she found the medication information from the orders. She stated both ticagrelor and clopidogrel were antiplatelet medications, not anticoagulants, and she stated they should be coded appropriately.During an interview with the Executive Director (ED) on 04/09/2026 at 1:55 PM, she stated the RNAC was responsible for coding MDS assessments. The ED stated staff reviewed the orders to learn what medications residents took and how they were classified. She stated she did not know how ticagrelor and clopidogrel were supposed to be classified.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to keep residents free from significant medication errors for 1 of 1 resident reviewed for psychiatric medication side effects, Resident (R) 50, and 1 of 5 residents reviewed for unnecessary medications, R6.The findings include: Review of the facility's policy titled, Physician Orders, dated [DATE], revealed The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. Further review revealed 'Professional Standards of Quality' means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific situation or setting. Review of the facility's policy titled, Medication Administration, dated [DATE], revealed Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Further review revealed the procedure included 11. Compare medication source (bubble pack, vial, etc. [et cetera; and so forth] with MAR [medication administration record] to verify resident name, medication name, form, dose, frequency, route, and time. Continued review revealed a. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action or common side effects, and b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician or if facility has adopted open medication pass times. Review of the policy revealed 14. Administer medication as ordered in accordance with manufacturer specifications. Further review revealed, 21. Medications that are not readily available for administration will be obtained from the Emergency Kit, drop shipped from the pharmacy, or obtained from an alternative pharmacy. Continued review revealed 22. Physicians will be notified timely of medication omissions. Instructions on how to proceed (example: administer medications when it becomes available) will be followed per physician order. 1. Review of R50's admission Record revealed the facility admitted R50 on [DATE] with diagnoses to include generalized anxiety disorder, bipolar disorder, major depressive disorder with psychotic symptoms, and psychotic disorder with hallucinations due to known physiological condition. Review of R50's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed R50 had a Brief Interview for Mental Status (BIMS) score of five of 15, which indicated the resident had severe cognitive impairment. Further review revealed the resident had active diagnoses that included bipolar disorder and psychotic disorder. Review of R50's Care Plan Report included a focus statement initiated [DATE], that indicated the resident received psychotropic medications. Interventions directed staff to administer medications as ordered by the physician (initiated [DATE]). Review of R50's Order Recap [Recapitulation] Report, for the timeframe from [DATE] through [DATE], contained the following orders: - Risperidone (an antipsychotic) 25 milligrams (mg) intramuscular (IM) one time a day every 14 days for psychotic disorder, with a start date of [DATE] and end date of [DATE]. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Risperidone 25 mg IM one time only for one day, with a start date of [DATE] and end date of [DATE]. - Risperidone 25 mg IM one time only for one day, with a start date of [DATE] and end date of [DATE] for. - Risperidone 25 mg IM one time only for one day and inject 25 mg IM every 14 days, with a start date of [DATE] and end date of [DATE]. - Risperidone 25 mg IM one time only for one day, with a start date of [DATE] and end date of [DATE]. Review of R50's [DATE] Medication Administration Record (MAR) revealed staff coded 9 on the MAR for risperidone 25 mg IM on [DATE] and [DATE], indicating the medication was not administered and to See Progress Notes. The MAR revealed staff documented the resident received risperidone 25 mg IM on [DATE] (17 days after the previous dose on [DATE]) and [DATE] (13 days following the previous dose). Review of R50's Progress Notes revealed an Administration Note, dated [DATE], that revealed risperidone 25 mg IM was not available. The note was electronically signed by Registered Nurse (RN) 4. Review of R50's [DATE] MAR revealed staff coded 9 on the MAR for risperidone 25 mg IM on [DATE] and [DATE], indicating the medication was not administered and to See Progress Notes. The MAR revealed staff documented the resident received risperidone 25 mg IM on [DATE] (29 days after the previous dose on [DATE]) and [DATE] (eight days following the previous dose). Review of R50's Progress Notes revealed an Administration Note, dated [DATE], that revealed risperidone 25 mg IM was On order and indicated the pharmacy was aware. The note was electronically signed by RN6. Review of R50's Progress Notes revealed an Administration Note, dated [DATE], that revealed risperidone 25 mg IM was On order. The note was electronically signed by Certified Medication Aide (CMA) 7. During an interview with RN4 on [DATE] at 9:16 AM, she stated if a resident's medication was unavailable for administration, staff documented it in the progress notes. She stated that staff were also expected to notify the physician and the family or resident if that happened. She further stated that if staff administered the medication, they documented it in the MAR. Referring to the note she authored on [DATE], RN4 stated she did not know why there was a delay. During an interview with RN6 on [DATE] at 3:47 PM, she stated if a resident's medication was unavailable for administration, it was documented on the MAR and in the progress notes. She stated the medications that were ordered for immediate delivery from the pharmacy could be delivered within three hours. She stated if the medication did not come quickly enough, staff should contact the physician. Regarding the note she authored on [DATE], RN6 stated she ordered the risperidone for immediate delivery from the pharmacy. She further stated that she did not administer it that day and did not know if someone else administered it later. (continued on next page)

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F 0760

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

During an interview with Pharmacist 8 on [DATE] at 10:09 AM, she stated risperidone 25 mg IM was scheduled every 14 days due to its pharmacokinetics (how the body absorbs, distributes, metabolizes, and excretes a medication). She stated that staff should document administrations and omissions of a medication in the MAR. When discussing the gaps in R50's risperidone administrations between [DATE] and [DATE] (17 days) and [DATE] and [DATE] (29 days), she stated maintaining therapeutic levels of the medication was a potential concern with the wide gaps.

During an interview with Psychiatric Nurse Practitioner 9 on [DATE] at 11:28 AM, she stated if staff did not administer medication due to unavailability, they contacted pharmacy and the physician. She stated staff had never reached out to her regarding the unavailability of risperidone. She stated her specific concern with gaps in R50's risperidone administration was that the medication would become subtherapeutic, and the resident might decompensate quickly if it started to wear off.

During an interview with the Director of Nursing (DON) on [DATE] at 1:09 PM, she stated she expected residents to receive their medications promptly. She stated she also expected staff to notify the physician if the resident did not receive their medication. She further stated she believed the delays in R50's risperidone administration was due to the pharmacy. Regarding the gaps in R50's medication administration, the DON stated she was concerned that the medication levels may become subtherapeutic.

During an interview with the Executive Director (ED) on [DATE] at 1:55 PM, she stated if staff did not administer a medication due to unavailability, they notified the pharmacist, resident, and physician. She stated medications could be delivered immediately from the pharmacy within four hours. She further stated she expected staff to administer medications as ordered.

2. Review of R6's admission Record revealed the facility admitted R6 on [DATE] with diagnoses to include atrial fibrillation, congestive heart failure, and hypertension (HTN).

Review of R6's quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of [DATE], revealed R6 had a Brief Interview of Mental Status (BIMS) score of 4 of 15, which indicated the resident had severe cognitive impairment.

Review of R6's Care Plan Report included a focus area initiated on [DATE] and revised on [DATE], that revealed the resident was at risk for impaired cardiac output related to arrythmia, congestive heart failure, HTN, anemia, episodes of orthostatic hypotension, and hypotension. Interventions directed the staff to administer medication as ordered (initiated [DATE]), and to check the resident's vital signs as ordered and to notify the physician of abnormalities (initiated [DATE]).

Review of R6's Order Recap [Recapitulation] Report, for the timeframe from [DATE] through [DATE], included the following orders:

- Midodrine hydrochloride (HCL) (an alpha-1 agonist) 5 milligrams (mg), one tablet by mouth three times a day for hypotension. The order specified to hold the medication from being administered if the resident's systolic blood pressure (top number; measures the pressure in the arteries when the heart beats) was greater than 115 millimeters of mercury (mmHg). The order revealed a Start Date of [DATE] and an End Date of [DATE].

- Metoprolol tartrate (a cardioselective beta blocker) 25 mg, one tablet by mouth two times a day for HTN. The order specified to hold the medication from being administered if the resident's systolic
(continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood pressure was less than 110 mmHg, or the resident had a pulse less than 50 beats per minute (BPM). The order revealed a Start Date of [DATE] and an End Date of [DATE]. - Metoprolol tartrate 25 mg, one tablet by mouth two times a day for HTN. The order specified to hold the medication from being administered if the resident's systolic blood pressure was less than 110 mmHg, or the resident had a pulse less than 50 BPM. The order revealed a Start Date of [DATE] and an End Date of [DATE]. - Verapamil HCL (a Group IV antiarrhythmic) 40 mg, one tablet by mouth two times a day for HTN. The order specified to hold the medication from being administered if the resident had a heart rate of less than 50 BPM or systolic blood pressure less than or equal to 110 mmHg. The order revealed a Start Date of [DATE] and an End Date of [DATE]. - Verapamil HCL 40 mg, one tablet by mouth two times a day for HTN. The order specified to hold the medication from being administered if the resident's systolic blood pressure was less than 110 mmHg, or the resident had a pulse less than 50 BPM. The order revealed a Start Date of [DATE] and an End Date of [DATE]. Review of R6's Order Summary Report, with active orders as of [DATE] included the following orders: - Metoprolol tartrate 25 mg, half a tablet by mouth two times a day for HTN. The order specified to hold the medication from being administered if the resident's systolic blood pressure was less than 110 mmHg, or the resident had a pulse less than 50 BPM. The order revealed a Start Date of [DATE]. - Verapamil HCL 40 mg, one tablet by mouth two times a day for HTN. The order specified to hold the medication from being administered if the resident's systolic blood pressure was less than 110 mmHg, or the resident had a pulse less than 50 BPM. Review of R6's [DATE] Medication Administration Record [MAR] revealed staff documented administering the following medication on the following dates when the resident's vital signs were outside the established parameters for administration: - Metoprolol Tartrate 25 mg: [DATE]- Staff (Licensed Practical Nurse [LPN] 1) documented the resident's systolic blood pressure was 106 mmHgXXX[DATE]- Staff (LPN1) documented the resident's systolic blood pressure was documented as 104 mmHgXXX[DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 97 mmHgXXX[DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 90 mmHg - Verapamil HCL 40 mg: [DATE]- Staff documented the resident's systolic blood pressure was 110 mmHgXXX[DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 110 mmHgXXX[DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 106 mmHg. - Midodrine HCL 5mg: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 119 mmHg. Review of R6's February 2026 MAR revealed staff documented administering the following medication on the following dates when the resident's vital signs were outside the established parameters for administration: - Metoprolol tartrate 25 mg: [DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 108 mmHg. [DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 97 mmHg. [DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 99 mmHg. [DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 105 mmHg. [DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 105 mmHg. [DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 95 mmHg. - Verapamil HCL 40 mg: [DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 108 mmHg. Review of R6's [DATE] MAR revealed staff documented administering the following medication on the following dates when the resident's vital signs were outside the established parameters for administration: - Metoprolol Tartrate 25 mg: [DATE]- Staff (LPN1) documented the resident's systolic blood pressure was104 mmHgXXX[DATE]- Staff documented the resident's systolic blood pressure was 105 mmHgXXX[DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 103 mmHgXXX[DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 105 mmHgXXX[DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 103 mmHgXXX[DATE]- Staff (LPN1) documented the resident's systolic blood pressure was 99 mmHg. - Verapamil HCL 40 mg: [DATE]- Staff documented the resident's systolic blood pressure was 97 mmHgXXX[DATE]- Staff documented the resident's systolic blood pressure was 107 mmHgXXX[DATE]- Staff documented the resident's systolic blood pressure was 107 mmHg. Review of R6's [DATE] MAR revealed staff documented administering the following medication on the following dates when the resident's vital signs were outside the established parameters for administration: - Verapamil HCL 40 mg: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE]- Staff documented the resident's systolic blood pressure was 104 mmHg. During an interview with LPN1 on [DATE] at 3:38 PM, she stated the process for administering a medication that had parameters established in the order, was to look at the parameters, and if the vital signs were out of range, the nurse should not give the medication; it should be held. LPN1 stated if the nurse was going to hold a medication, they marked the medication as being held in the electronic medical record by choosing a reason the medication was held, which was indicated by a number code. LPN1 stated if a medication documented on the MAR had no number with the nurse's initials, then the medication was given. During the interview, LPN1 reviewed R6's [DATE], February 2026, [DATE], and [DATE] MARs, and stated she was not aware that she had not followed the physician's orders so many times. LPN1 stated she documented that she gave the medications and did not document on the MAR that she had held them from being administered. She stated that the potential effects of giving blood pressure medication when the resident's blood pressure was already low could result in the resident's blood pressure dropping low, causing the resident to pass out, or their heart to stop beating. She stated she was not aware she had not paid attention to the parameters on R6's orders that many times in the previous three months. LPN1 stated if she had not documented that she held the medication and a number code for why the medication was held, then she documented that she gave the medication and had not followed the physician's orders, because the blood pressures were too low to give the medication. During an interview with Registered Nurse (RN) 2 on [DATE] at 2:35PM, she stated if a medication had parameters established in the order, depending on what they were, the nurse held a medication if the vitals were outside the established parameters. She stated there were some orders that even required a physician to be notified if the blood pressure or blood sugar were at certain levels. RN2 stated when there was an order with parameters, staff documented the medication as being held with vitals outside of parameters, which she believed was a #4. She stated if there was not a #4 coded on the MAR, or any other number other than a 0 under the nurses' initials, it meant the medication was given. RN2 stated it would be a medication error to give a medication if the vital signs were outside of the parameters. During an interview with Nurse Practitioner (NP) 3 on [DATE] at 11:17 AM, who was R5's primary care NP, she stated that parameters were set in place for the purpose of potentially having nurses administering medications who were not aware of what appropriate parameters for low/high blood pressures, heart rates, or blood sugars were. She stated it would be a medication error to give medication if the parameters were not met. NP3 stated the nurses were able to document they held a medication from being administered by using a number coding system on the MAR to indicate why it was held. She stated if there was not a number above or below the nurses' initials on the MAR, then the check mark meant they administered the medication. During the interview, NP3 reviewed R6's MARs for the months of [DATE], February 2026, [DATE], and [DATE], and validated there were several days the staff documented the blood pressure medications as administered on the MAR with vital signs outside the ordered parameters and should have been marked as being held from being administered. She stated most of the instances the medication was not marked as held, was by one nurse, LPN1. She stated when blood pressure medications were given with low blood pressures, it could cause the resident's blood pressure to drop extremely low to the point the resident could become unconscious or require interventions such as intravenous fluids in bolus. She stated it could even result in cardiac arrest with a need for cardiopulmonary resuscitation (CPR) and/or to be sent to the emergency room if the resident was a full code. NP3 stated it was even more important to pay attention to the blood pressure parameters when there was more than one blood pressure medication being given, like for R6. NP3 reviewed the documented blood pressures for the days when the blood (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressures were outside of parameters, and the medications were documented as given, and she stated there were no patterns in the low blood pressure reading following the administration of the medications outside of the established parameters. NP3 stated she expected the nurses to follow the parameters given by the physicians. During an interview with the Director of Nursing (DON) on [DATE] at 2:40 PM, she stated if the nurses did not document that they held a medication from being administered, and a numeric coded reason why they did not give the medication on the MAR, they must assume the medication was given, even when the vitals were outside of the parameters. She stated her expectation was for the nurses to administer the medications with parameters as they were ordered, and to notify the physician as appropriate. During an interview with the Executive Director (ED) on [DATE] at 1:41 PM, she stated she expected the nurses to follow the physician's orders, and if there were parameters on the orders, the nurses were to follow them. She stated the nurses needed to document accurately if they gave or held medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185415	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elliott Nursing and Rehabilitation	20 Howards Creek Road Sandy Hook, KY 41171

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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 - Few	Provide and implement an infection prevention and control program. Based observation, interview, record review, and review of the facility's policy, the facility failed to ensure nursing staff completed handwashing and glove changes between wound care tasks to prevent potential infection for 1 of 2 residents observed for wound care, Resident (R) 46.The findings include:Review of the facility's policy titled, Infection Prevention & Control Program, revised 07/17/2025, revealed the purpose of the policy was To provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines.Review of the facility document titled, Validation Checklist Wound Care, undated, revealed the purpose of the checklist was To determine if the individual performing wound care is doing so in accordance with facility policy. Further review of the checklist revealed a column titled Procedures Observed, which included 12. Removed dressing and placed in appropriate receptacle; 13. Performed hand hygiene and donned clean gloves; and 14. Cleansed wound thoroughly with prescribed cleansing agent, taking care to not contaminate other skin surfaces or other surfaces of the wound.Review of R46's admission Record revealed the facility admitted R46 on 02/04/2022 with diagnoses to include type 2 diabetes with hyperglycemia, heart failure, essential hypertension, and lymphedema.Review of R46's significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/23/2026, revealed R46 had a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated the resident had moderate cognitive impairment. Further review revealed the resident had one unstageable pressure ulcer and received pressure ulcer care.Review of R46's Care Plan Report revealed a focus area initiated 01/14/2026, that indicated the resident had an unstageable pressure area to their right heel. Interventions directed staff to provide wound treatments as ordered (initiated 01/14/2026).Review of R46's Order Summary Report, with active orders as of 04/07/2026, contained the following orders: Clean right heel with wound cleaner, pat dry, apply a silver-impregnated wound dressing to wound bed, cover with non-border dressing, secure with a sterile gauze and tape, to be completed one time a day for 15 days to aide in wound healing. The order had a start date of 04/06/2026; Cleanse left heel with wound cleaner, pat dry, apply a skin barrier product, cover with heel foam and secure with tape, to be completed once a day for skin integrity. The order had a start date of 04/05/2026.Observation of wound care for R46 on 04/08/2026 at 11:18 AM, revealed Registered Nurse (RN) 2, assisted by the Director of Nursing (DON), completed wound care for the resident's bilateral heel wounds. RN2 prepared the bedside table by cleaning it and placing a barrier down. She placed her clean supplies on the barrier and began to open and prepare her dressings, dating and initialing them prior to placement on the resident's feet. While RN2 prepared the dressings, the DON stated she was going to remove the old dressings from both heels at once and offered to cleanse the wounds for RN2 as well. The DON, with gloved hands, removed the dressings from both Resident 46's heel wounds and threw them in the trash. Without removing her gloves and performing hand hygiene, the DON grabbed a small stack of sterile gauze pads and a bottle of wound cleanser from the bedside table. Holding the sterile gauze pads in her hand, she sprayed them with a wound cleanser and washed the resident's right heel. Without removing her gloves and performing hand hygiene between wounds, the DON reached onto the bedside table and grabbed another small stack of gauze in her hand and cleansed the resident's left heel with them. The remainder of the treatment to R46's bilateral heel wounds was completed by RN2.During an interview with RN2 on 04/08/2026 at 2:07 PM, she stated she was unsure if there was a policy on treating more than one wound at a time; however, she would change her gloves and perform hand hygiene before the procedure, after removing the soiled dressings, after cleansing each wound, and at the end of the procedure. She stated she would do this process over again for the second wound. RN2 stated cross-contamination could occur if two wounds were addressed at the same time. She stated she did not see any breaches in infection control practices as she had her back to the DON prepping supplies; however, if the DON did not (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Elliott Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 20 Howards Creek Road Sandy Hook, KY 41171	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	remove her gloves after taking off the soiled dressings and then cleansed both heel wounds without washing her hands, then there was a breach of infection control due to cross-contamination issues between the wounds, and germs from the dirty dressings on the gloves.During an interview with the Assistant Director of Nursing (ADON), who was also the Infection Preventionist (IP), on 04/09/2026 at 1:56 PM, she stated she expected staff to perform hand hygiene and glove changes between dirty and clean aspects of wound care. She stated the staff should not be addressing more than one wound at a time, and even more so if the wounds were in close proximity to each other.During an interview with the DON on 04/08/2026 at 3:02 PM, she stated she did not change her gloves after taking off the soiled dressing on both of the resident's feet, and she had used the same gloves when she washed both of the resident's heel wounds. She stated she also touched the resident's wound cleanser bottle as well. The DON stated, I know better than that. I was just trying to help [RN #2] out, was going fast and must have gotten nervous myself and messed it all up. The DON stated she expected staff, including herself, to follow the infection control policy for dressing changes and to follow the wound care protocol to prevent infections.During an interview with the Executive Director (ED) on 04/09/2026 at 1:55 PM, she stated her expectation was for staff to follow the infection control policies and the wound care protocol.

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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 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and review of the facility's policy, the facility failed to dispose of refuse in a sanitary manner. The deficiency had the potential to affect all residents of the facility.The findings include:Review of the facility's policy titled, Garbage and Refuse, dated 10/01/2025, revealed the purpose was To ensure the safe, sanitary, and compliant handling, storage, and disposal of garbage and refuse in accordance with Federal, State, and Local regulations while maintaining a clean, safe, and healthy environment for residents/patients, Care Team Members, and visitors. Further review revealed the procedure included A. Garbage and refuse containers will be kept clean and covered when not in use/continuous use; and B. Outside dumpsters will be monitored to be kept clean, free of surrounding litter, lid closed, and inaccessible to pests.Observation of the dumpsters with the Dietary Manager (DM) on 04/06/2026 at 9:04 AM, revealed dumpsters inside a wooden fenced area located just outside the kitchen, near the front of the facility, which was not closed or gated. Further observation revealed trash laid scattered around the garbage dumpster that included six gloves, two empty boxes for medical gloves, and a garbage bag sitting in the corner of the fenced dumpster area. Continued observation revealed one of the dumpster lids was open.During immediate interview with the DM on 04/06/2026 at 9:04 AM, she stated the maintenance department was responsible for keeping the dumpster area clean and dumpster lids were supposed to be closed.Further observation of the dumpsters 04/06/2026 at 9:21 AM, the lids to the dumpsters remained open.Further observation of the dumpsters and concurrent interview with the DM on 04/08/2026 at 2:30 PM, the dumpster lids remained open. The DM stated she did not know who kept leaving the dumpster lids open.During an interview with the Maintenance Director on 04/09/2026 at 8:46 AM, he stated he was responsible for the dumpster area. He stated that every time he went to the dumpsters, he made sure they were closed, and he found them open on a regular basis. The Maintenance Director stated he stressed the importance of closing the lids to staff, and explained to staff that raccoons, opossums, and cats were in the area.During an interview with the Director of Nursing (DON) on 04/09/2026 at 1:09 PM, she stated when staff discarded items in the dumpsters, they were expected to close the lids on the dumpsters.During an interview with the Executive Director (ED) on 04/09/2026 at 1:55 PM, she stated that anybody who used the dumpsters was responsible for making sure the lids were closed. She stated that if someone was out there and they saw debris, they were expected to clean up the debris. The ED further stated it was important to keep the lids closed because animals might get into the trash, and the facility wanted to keep it clean and closed to deter vermin.