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	08/29/2024

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and facility policy review, the facility failed to ensure the resident(s) right to be free from abuse and neglect for one of one sampled resident. (R9) R9 stated staff left the room while providing her a shower, which made her feel scared. R9 was a quadriplegic and unable to call for help. The findings include: Review of a facility policy titled, Abuse Prohibition Standard of Practice, dated 11/2016 and revised 07/2022, revealed the facility would prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property and to ensure reporting and investigating of alleged violations in accordance with Federal and State laws. Review of a facility policy titled, Safety and Supervision Standard of Practice, dated 07/2020 and revised 02/2021, revealed the facility strived to make the environment as free from accident hazards as possible and resident safety and supervision were facility-wide priorities. Review of a facesheet revealed the facility admitted R9 on 11/04/2016 with diagnoses to include: lymphedema, not elsewhere classified, morbid obesity (severe) due to excess calories, and Multiple sclerosis. Review of the resident's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/04/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of a 15 out of 15, indicating the resident was cognitively intact. Review of a grievance form dated 07/16/2024 at 3:00 PM, revealed R9 stated she was being given a shower by CNA14. R9 stated she asked CNA14 twice to raise her arm and wash under it. CNA 13 replied with I am, threw down the hose and stated she was done and going to get another aide, leaving R9 in the room naked, soaked and unattended to. Section II documented action taken was education was provided to staff, as well as coaching and counseling. The State Survey Agency (SSA) Surveyor was unable to interview the nurse whom provided the education as she was out of the facility on medical leave. During an interview on 08/26/2024 at 8:37 AM with R9, she stated on 07/16/2024, CNA14 was helping her with a shower in the shower room and kept reaching across her body covering her face. R9 stated she was claustrophobic and kept telling the staff member to stop. R9 stated the staff member became (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	angry, throwing the shower nozzle to the floor and walking out of the shower room , leaving her on the shower table alone with the water still running. R9 stated she began to yell for help but nobody could hear her and she felt scared. R9 stated she felt like she laid there forever however it was about fifteen minutes in reality. R9 further stated two other staff members entered the room and stated CNA14 told them R9 kicked CNA14 out of the shower room. During an interview on 08/28/2024 at 5:43 PM with Certified Nursing Assistant (CNA) #14, she stated she was giving R9 a shower and R9 kept complaining that she wasn't doing it correctly and to get out and find someone else. CNA14 stated she did leave the room to find another staff member to take over and left R9 laying on the shower table. CNA14 stated she should have stopped the shower, cover R9 with a sheet and pull the cord to alert other staff she needed assistance. CNA14 stated R9 could have fell off of the table and it was not appropriate to have left the resident alone. CNA14 stated she had only been employed at the facility a few weeks at the time and was reeducated by a nurse. During an interview on 08/29/2024 at 2:37 PM with the Director of Nursing (DON), she stated a resident should never be left alone in the shower room. The DON stated CNA14 should have used the pull cord in the shower room and waited until someone could relieve her before leaving the room. The DON stated CNA14 was reeducated immediately. During an interview on 08/29/2024 at 3:39 PM with the Administrator she stated, the facility does not want staff to leave anyone unattended in the shower room. The Administrator stated R9 was unable to call for help and it was a safety concern. The Administrator further stated CNA14 should have used the emergency pull cord or stuck her head out of the door and yelled for someone to come help her.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents who are unable to carry out activities of daily living receive the necessary services to maintain good grooming and personal hygiene for ten (Resident (R) 9, R14, R25, R26, R35, R39, R40, R42, R108, and R254) of 21 sampled residents. Residents did not receive regularly scheduled showers and/or baths, and grooming/hygiene, including nail care, as needed. The findings include: Review of a facility policy, titled Activities of Daily Living (ADLs), dated 10/2020, revealed the facility would work to provide care and services to residents that were person-centered, and honor and support each resident's preferences, choices, values, and beliefs. The policy stated the facility protocol would be to provide the resident the appropriate care and services to maintain or improve his/her ability to carry out the ADLs. The facility would provide care and services for the following ADLs: hygiene (bathing, dressing, grooming, oral care) and any resident who was unable to carry out ADLs would receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. However, the facility did not include specifics related to the provision of these services. 1. Review of R9's admission Face Sheet revealed the facility admitted the resident on 11/04/2016 with diagnoses including multiple sclerosis (MS), morbid obesity, and type 2 diabetes. Review of R9's Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/04/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated the resident was cognitively intact. Per the MDS, the resident was dependent on staff for bathing and had no refusals of care. Review of the resident's care plan revealed the resident required two-person assistance with the use of a mechanical lift. Review of the resident's shower/bath schedule revealed the resident was supposed to receive a shower twice a week. Per the shower sheet, each day was to be documented that either a bath was given, a shower was given, the activity did not occur, or the resident refused care. Review of R9's shower sheets from 11/01/2023 through 01/31/2024 revealed no documented showers, baths, or refusals between 11/12/2023 and 11/20/2023; between 12/04/2023 and 12/10/2024; between 12/15/2023 and 12/22/2023; between 12/24/2023 and 01/05/2024; or between 01/07/2024 and 01/21/2024. During an interview with R9 on 08/26/24 at 08:37 AM, she stated her showers were often not provided on her shower day because of staffing issues. She further stated it was very depressing when she did not receive a shower. During an interview with Certified Nursing Assistant (CNA) 3 on 08/27/24 at 07:49 PM, she stated R9 required two people for her care and preferred her shower during the day. CNA3 stated R9's showers were not always provided on her scheduled shower day because there were not enough people to help on the floor. 2. Review of R14's admission Face Sheet revealed the facility admitted the resident on 10/12/2023 with diagnoses including Parkinson's disease, quadriplegia, and type 2 diabetes. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R14's MDS, with an ARD of 08/10/2024, revealed the resident had a BIMS score of 12/15, which indicated the resident was moderately cognitively impaired. Per the MDS, the resident was dependent on staff for Activities of Daily Living (ADLs) and did not refuse case. Review of R14's care plan, with a date of 10/12/2023, revealed the resident would be provided ADL assistance per assessment. The resident's shower schedule was twice weekly. Review of R14's shower sheets from 05/26/2024 through 08/24/2024 revealed documentation of partial or total bed baths, but no showers. Further review revealed no documentation of any bath hygiene between 06/21/2024 through 06/30/2024; 07/23/2024 through 07/31/2024; or 08/07/2024 through 08/13/2024. Observation on 08/26/24 at 9:39 AM revealed R14's fingernails were approximately one to one and a half inches long; were yellowed in color; and dirt was observed underneath all ten fingernails. During an interview with R14 on 08/26/2024 at 9:39 AM, he stated he was not sure the last time his nails were trimmed. He further stated he liked to have his nails trimmed and clean. Further interview with R14 revealed that yesterday (08/25/2024) was the first time in about six months he was offered a bath. 3. Review of R26's admission Face Sheet revealed the facility admitted the resident on 04/05/2024 with diagnoses including legal blindless, right below the knee amputation (BKA), and type 2 diabetes. Review of R26's MDS, with an ARD of 07/04/2024, revealed the resident had a BIMS score of 14/15, which indicated the resident was cognitively intact. Per the MDS, the resident required assistance with bathing/showering, and did not refuse care. Review of the care plan, dated 04/04/2024, revealed the resident would be provide the level of assistance required with ADLs. The resident's shower schedule was twice weekly. a. During interview with R26 on 08/27/24 at 8:36 AM, he stated he had not received a shower last month. Review of R26's shower sheets from 05/27/2024 through 08/24/2024 revealed no documented showers, baths, or refusals between 07/07/2024 and 08/09/2024. During an interview with CNA5 on 08/28/2024 at 9:14 AM, she stated R26 was scheduled for a shower yesterday, but it was missed because she did not have time or help. b. Observation on 08/27/2024 at 8:36 AM revealed R26's fingernails were approximately one to one and a half inches long, yellow in color, brittle, and dirty underneath. During an interview with R26 on 08/27/2024 at 8:36 AM, he stated he wanted to have his nails trimmed and cleaned. He further stated he had a visual impairment and frequently used his hands when he ate finger type foods. During an interview with CNA 10 at 08/29/2024 at 9:55 AM, she stated the CNAs trimmed residents' fingernails unless the resident was a diabetic. If the resident was diabetic, then nursing staff was responsible for nail care. CNA 10 further stated it was important fingernails were kept trimmed and cleaned because of cleanliness, especially when the resident ate. 4. Review of R25's admission Face Sheet revealed the facility admitted the resident on 03/20/2019 with diagnoses including left sided paralysis following a stroke and contracture of left hand and left wrist. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R25's MDS, with an ARD of 08/06/2024, revealed the resident had a BIMS score of 14/15, which indicated the resident was cognitively intact. Per the MDS, the resident required assistance with bathing/showering and did not refuse care. The resident's care plan, dated 11/08/2019, noted the resident had a self-care deficit and required assistance with ADLs. Review of R25's shower sheets from 05/26/2024 through 08/25/2024 revealed no documented showers, baths, or refusals between 07/06/2024 and 08/05/2024. Observation on 08/25/24 at 11:47 AM revealed R25's hair was dirty, greasy, and matted to the resident's head. During interview with R25 on 08/25/2024 at 11:47 AM, he expressed concern about the frequency of baths and stated it had been about a month since he received a shower or bath. In an additional interview with R25 on 08/27/2024 at 8:48 AM, he stated he still had not received a shower. He further stated he wanted a bath because he felt dirty. 5. Review of R35's admission Face Sheet revealed the facility admitted the resident on 01/06/2023 with a diagnosis of left sided paralysis following a stroke. Review of R35's MDS, with an ARD of 08/20/2024, revealed the resident had a BIMS score of 15/15, which indicated the resident was cognitively intact. Per the MDS, the resident was dependent on staff for showers/bathing and did not refuse care. The care plan, dated 01/17/2023, noted the resident had a self-care deficit and staff were to provide ADL assistance per the MDS assessment. The resident's shower schedule was twice weekly. Review of R35's shower sheets from 05/26/2024 through 08/25/2024 revealed no documented showers, baths, or refusals between 07/19/2024 and 07/31/2024 or between 08/11/2024 and 08/25/2024. During an interview with R35 on 08/25/2024 at 11:15 AM, she stated her scheduled showers were not always provided. Observation during this interview revealed the resident had dirty, uncombed hair. 6. Review of R40's admission Face Sheet revealed the facility admitted the resident on 08/18/2022 with diagnoses including, acute and chronic respiratory failure, type 2 diabetes, and stroke. Review of R40's MDS, with an ARD of 07/31/2024, revealed the resident had a BIMS score of 15/15, which indicated the resident was cognitively intact. Per the MDS, the resident required assistance with bathing and did not refuse care. The resident's care plan, dated 08/18/2022, noted the resident required assistance with ADLs per their assessment. The resident's shower schedule was twice weekly. Review of R40's shower sheets from 11/01/2023 through 01/31/2024 revealed no documented showers, baths, or refusals between 11/08/2023 and 11/13/2023 or between 01/03/2024 and 01/10/2024. Review of R40's shower sheets from 05/26/2024 through 08/24/2024 revealed no documented shower, bath, or refusals between 07/19/2024 to 07/31/2024 or between 08/11/2024 to 08/25/2024. No observation or interview was conducted as the resident was out to the hospital during the survey. 7. Review of R108's admission Face Sheet revealed the facility admitted the resident on 10/17/2023 with diagnoses including paraplegia and type 2 diabetes. Per this closed record, the resident's discharge date was 05/08/2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R108's MDS, with an ARD of 04/03/2024, revealed this resident required assistance with bathing. Per the care plan, dated 10/16/2023, the resident had a self-care deficit and ADL assistance was to be provided as required per assessment. Review of R108's shower sheets from 11/01/2023 through 01/31/2024 revealed one documented entry on 12/01/2023 for a shower. 8. Review of R254's admission Face Sheet revealed the facility admitted the resident on 12/04/2023 with diagnoses that included paralysis following a stroke, dementia, and congestive heart failure (CHF). Per this closed record, the resident's discharge date was 01/11/2024. Review of R254's shower sheets from 12/04/2023 through 01/10/2024 revealed no documented showers, baths, or refusals between 12/04/2023 and 12/10/2023. 9. Review of a face sheet revealed the facility admitted R39 on 02/15/2024 with diagnoses including cognitive communication deficit, history of transient ischemic attack (TIA) and cerebral infarction, and unspecified dementia with other behavioral disturbance. Review of a Quarterly MDS, with an ARD of 08/21/2024, revealed the facility assessed R39 to have a BIMS score of 3/15 indicating the resident had severe cognitive impairment. Per the MDS, the resident needed staff assistance with bathing and did not refuse care. Review of R39's shower sheets from 05/27/2024 through 08/28/2024 revealed no documented showers, baths, or refusals from 07/07/2024 through 08/05/2024. 10. Review of a face sheet revealed the facility admitted R42 on 10/17/2022 with diagnoses including cervical disc disorder with myelopathy, major depressive disorder, and neurogenic bowel. Review of a Quarterly MDS, with an ARD of 07/28/2024, revealed the facility assessed R42 to have a BIMS score of a 15/15 indicating the resident was cognitively intact. Per the MDS, the resident needed staff assistance with bathing and did not refuse care. Review of R42's shower sheets from 05/27/2024 through 08/28/2024 revealed no documented showers, baths, or refusals from 07/04/2024 through 07/12/2024, 07/15/2024 through 07/22/ 2024, and 08/15/2024 through 08/26//2024. During an interview with R42 on 08/29/2024 at 1:10 PM, he stated he did not receive showers regularly. R42 stated he has had to wait several days between showers due to a lack of staff to assist. R42 stated he had waited up to a week in the past. R42 stated he did like to take his showers and it was frustrating to him when he could not receive a shower. R42 further revealed there had been many times that staff wouldn't even ask him if he wanted a shower because they did not have enough help. During an interview with CNA5 on 08/28/2024 at 9:14 AM, she stated that typically, four to five showers were completed on day shift, and she was unsure about night shift. CNA5 stated sometimes they had a shower aide, but lately the facility was short staffed. She further stated when they had one aide per hall and the mechanical lift required two staff, it was hard to get showers completed. CNA5 stated residents had complained to her about missed showers. She further stated residents had missed outside appointments because they told her they felt dirty. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with CNA10 on 08/29/2024 at 9:55 AM, she stated residents were usually showered twice a week; however, some residents had complained to her their showers were missed. During an interview with CNA9 on 08/28/2024 at 1:57 PM, she stated if a shower aide was not scheduled to work, the CNA on the floor was responsible for showers and she found it difficult to give showers on top of her other assigned duties. CNA9 stated she often worked without a shower aide scheduled and they were short staffed. During an interview on 08/29/2024 at 10:24 AM with Licensed Practical Nurse (LPN) 5, she stated residents had complained their showers were not received. She further stated some days they had a shower aide and that helped, but other days there was not enough staff to make certain all showers were completed. During an interview with the Unit Manager (UM) on 08/29/2024 at 10:48 AM, she stated there should not be any reasons showers were not provided unless a resident refused. During an interview with the Director of Nursing (DON) on 08/29/2024 at 2:37 PM, she stated residents have assigned shower days twice a week. The DON stated she expected the facility to be staffed appropriately to be able to provide the care the residents required, and she thought the facility had been. Further interview with the DON, on 08/29/2024 at 3:03 PM, revealed she had no concerns with the overall hygiene of residents. She further stated it was her expectation nurses helped with ADL's if needed. During an interview with the Administrator on 08/29/2024 at 3:39 PM, she stated she was aware there was work to be done, and the facility was working on an action plan related to showers. The Administrator stated she wanted to ensure a shower aide was staffed at least three days a week. She stated showers should not be missed and the CNA working the floor was responsible to ensure the resident received their shower or bath. The Administrator stated their goal was to ensure all scheduled showers were given, adding that there should never be a day a resident did not receive their scheduled shower.

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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 observation, interview, and record review, the facility failed to ensure one (Resident (R) 203) of 21 sampled residents was free from a significant medication error. R203 was sent to the hospital for pain control after not receiving her routinely ordered controlled pain medication for over two days after admission. The findings include: Review of a facility policy titled, Medication Administration Standard of Practice, dated 10/2020, revealed medications would be administered in a safe and timely manner, and as prescribed. 1. Observation on 08/26/2024 at 2:06 PM revealed R203 ambulating on Heritage Hall in her wheelchair. The resident was yelling out for help to use the bedpan and stating she was in pain. Interview at this time with R203 revealed she was admitted to the facility on the night of 08/23/2024. R203 stated she had taken Oxycodone (a controlled opioid medication used to treat moderate to severe pain) and Lyrica (medication used for nerve and muscle pain) for at least four years prior to admission. However, she continued, she had not received her scheduled pain medication since admission because the facility staff told her the physician had not sent in a prescription and they had not received her medication. R203 stated she had requested to be transferred to the emergency room for pain control. Additional observation on 08/26/2024 at 2:17 PM revealed three Emergency Management personnel transporting R203 to the hospital via ambulance. The resident was evaluated and treated in the emergency room but was not admitted , to the hospital, and returned to the facility around 3:00 AM on 08/27/2024. Review of a face sheet revealed the facility admitted R203 on 08/23/2024 with diagnoses including chronic migraine without aura, a displaced trimalleolar fracture of the left lower leg, chronic pain, muscle wasting and atrophy, and rheumatoid arthritis. Review of the resident's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/26/2024 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14/15, which indicated the resident was cognitively intact. Review of physician orders for R203 revealed routine orders for Lyrica (Pregabalin) 100mg (milligrams) one capsule twice a day and Oxycodone 10mg tablet one tablet every eight hours with a start date of 08/23/2024. In addition, the resident had orders for Tylenol 325 mg, two tablets as needed (PRN) for pain, as well as Tylenol 650 mg rectally PRN for pain. Although the resident was admitted on [DATE], review of the 08/01/2024 - 08/27/2024 Medication Administration Record (MAR) revealed the first dose of Lyrica 100 mg was not documented as given until 08/24/2024 at 7:00 PM (one day after admission). Per the MAR, the resident did not receive the first dose of Oxycodone 10mg tablet until 08/24/2024 at 11:00 PM (over a day after admission) Review of the MAR revealed these medications were documented as being administered by Licensed Practical Nurse (LPN) 8. During an interview with LPN8 on 08/28/2024 at 7:10 PM, he stated he did not administer Oxycodone or Lyrica on 08/24/2024 and if the MAR reflected that, it must have been a documentation error. Further interview with LPN8 revealed that he did not administer the medications because they had not yet arrived at the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although the MAR documented that the medications were given on 08/24/2024, review of a packing slip confirmed the facility did not receive R203's Oxycodone 10mg tablets and Pregabalin 100mg capsules until 08/26/2024. The Oxycodone and Pregablin were not administered until 08/27/2024 at 7:00 AM, after the resident returned from the hospital. Further review of the 08/01 - 08/27/2024 MAR revealed that the PRN Tylenol was not administered during the two+ days from admission on [DATE], till hospital transfer on 08/26/2024, and review of the resident's Progress Notes revealed no evidence of pain. Review of an inventory list from the facility's emergency Cubex supply (E-kit) revealed the facility had six Oxycodone-Acetaminophen 10/325mg tablets in stock/available for use. However, review of the transaction log, dated 08/23/2023 through 08/27/2024, revealed staff failed to remove the medication from the Cubex and administer the ordered Oxycodone to R203. During an interview on 08/27/2024 at 9:30 AM, Registered Nurse (RN) 1 stated she was an agency nurse. RN1 stated LPN5 was responsible for admitting R203. Although there was a physician's prescription on 08/23/2024 for the Oxycodone and Lyrica. LPN5 did not obtain the needed hard copy to order the pain medications from the pharmacy. RN1 stated she called the medical director on 08/24/2024 to request a prescription be sent to the pharmacy and the physician replied with Thank you. RN1 stated she did not work on 08/25/2024 and when she returned on 08/26/2024, R203's pain medication was still not stocked in the medication cart. RN1 stated she called the medical director again and he instructed her to notify his office and it would be taken care of. RN1 stated she did call the medical director's office to request the prescriptions be sent to the pharmacy. Although there was no evidence in the clinical record that the resident experienced pain on 08/23 - 08/25/2024, RN1 stated that on 08/26/2024, R203 began to complain of increased pain and asked to be sent to the hospital for an evaluation. RN1 stated typically the resident would admit with their pain medication with them or a written prescription. RN1 stated if the resident did not have a prescription, the admitting nurse was responsible to obtain the prescription and fax the prescription to the pharmacy. RN1 stated the pharmacy usually delivers the medication on the same day they receive the prescription. RN1 further stated if the resident had not received their medication, a nurse could pull medication from the Cubex; however, she did not know if this had been done for R203. RN1 confirmed that the facility ultimately did receive R203's medication during the time she was in the emergency room on [DATE]. During an interview on 08/29/2024 at 3:02 PM with LPN5, she stated she worked through an agency and had worked regularly at the facility since 03/2024. LPN5 stated she was responsible for R203's admission on [DATE]. LPN5 stated R203 did not have a hard copy of the prescriptions for Oxycodone or Lyrica, and it was her error, adding she should have asked someone what to do. LPN5 further stated she placed R203's admission papers in the tray for the administration team to review and assumed they would order R203's medications. LPN5 stated she misunderstood the process and should have asked someone since she did not know, and she should have called the medical director or ensured the sending facility had actually sent a prescription with the resident. LPN5 stated the normal process would be to obtain a hard copy of the prescriptions and fax it to the pharmacy, but she was tired and had several admissions that day. During an interview with LPN8 on 08/28/2024 at 7:10 PM, LPN8 stated he had worked on 08/24/2024 and R203's medications had not been received, so he called the pharmacy and was made aware they had not received a prescription. LPN8 stated he assumed the admitting nurse had not faxed the prescription, so he called the medical director. LPN8 stated the medical director replied with Thank you, and he did not hear anything back the remainder of the evening. He stated on 08/25/2024 when he reported to (continued on next page)

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	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elizabethtown Nursing and Rehabilitation Center	1101 Woodland Drive Elizabethtown, KY 42701

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	work, R203 still did not have her medications so he again called the medical director, who responded with Thanks, I'll take care of it LPN8 stated the admitting nurse should have ensured a hard copy of the resident's prescriptions had been faxed to the pharmacy so the resident would have had her medication. An attempt to conduct a telephone interview with the medical director (MD) on 08/28/2024 at 7:30 PM was unsuccessful and the MD did not return the telephone call. During an interview on 08/29/2024 at 2:37 PM with the Director of Nursing (DON), she stated she was not made aware until 08/27/2024 that R203 had not received her scheduled pain medications. The DON stated the admitting nurse was responsible for obtaining all orders for the resident. The DON stated on 08/27/2024, they learned that the physician had initially sent R203's prescription to an incorrect pharmacy. The DON stated that once R203 complained of increasing and uncontrolled pain on 08/26/2024, it was necessary to send the resident to the emergency room. The DON stated she expected nursing staff to obtain orders and send the prescription to the pharmacy during the admission process. The DON further stated she expected to be notified immediately so a decision could be made in a timelier manner and the resident could receive their prescribed medications. During an interview with the Administrator on 08/29/2024 at 3:39 PM, she stated she expected medications to arrive from the pharmacy in a timely manner and staff should ensure they had received the appropriate orders. The Administrator stated there should have been better communication with the staff, physician, and pharmacy to ensure R203's medications were received.