

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/25/2025
NAME OF PROVIDER OR SUPPLIER Elkton Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 506 Allensville Road Elkton, KY 42220	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>(continued on next page)</p>

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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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 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</p>		