STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185200	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Letcher Manor	73 Piedmont Drive Whitesburg, KY 41858

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44974 Based on observation, interview, record review and review of facility policy, the facility failed to provide adequate supervision and assistance devices to ensure the safety of its residents for 1 of 31 sampled residents (Resident (R)39). The facility allowed R39 to roam freely into other residents' hallways and rooms without providing adequate supervision of the resident to ensure the safety and well-being of all residents. The findings include: Review of the facility's investigation initiated on 09/22/2024, revealed on 09/22/2024, R8 followed R39 down the hall, with both residents being in wheelchairs. Per review, R8 was yelling, Hey, hey at R39 and making motions with his hands. Continued review revealed R8 grabbed R39's arm and wheelchair, and Registered Nurse (RN) 1 immediately separated the residents. Further review of the investigation revealed both residents were placed on one to one (1:1) supervision while the investigation was being completed. 1. Review of R8's Face Sheet revealed the facility admitted the resident on 10/21/2015, with diagnoses of aphasia following cerebral infarction, anxiety, and hemiplegia. Review of R8's Annual Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 10/23/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eight out of 15, which indicated moderate cognitive impairment. 2. Review of R39's Face Sheet revealed the facility admitted the resident on 03/02/2017, with diagnoses of vascular dementia, bipolar disorder, and Moyamoya disease (a rare condition affecting the blood vessels of the brain). Review of R39's Annual MDS Assessment with an ARD of 07/08/2024, revealed the facility assessed the resident to have a BIMS score of nine of 15, indicating moderate cognitive impairment. Review of R39's Care Plan revealed a focus for elopement risk related to wandering, initiated 10/01/2018, with a goal that R39 would remain safe in the facility. Per review, the interventions included when R39 exhibited increased wandering, staff were to implement diversional activities. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 02/24/2025 at 5:12 PM, revealed R39 wheeling himself into the doorway of another resident's room (room [ROOM NUMBER]). R8 (who was sitting in the hallway just outside his room [ROOM NUMBER]), told R39 to get out of room [ROOM NUMBER], and informed R39 he had no business in that room. Continued observation revealed R39 going down a hallway, out the door of that hallway, around and up another hall, and neither hallway was the hallway where R39's room was located. Further observation revealed R39 made multiple trips past R8's room. (During the observation, staff were not observed to be providing diversional activities as per the resident's care plan). During interview on 02/25/2025 at 10:15 AM, R8 stated R39 had taken smokeless tobacco from his room, and another resident had seen R39 do it; however, he could not recall who that resident was. (R8 had speech difficulties related to a prior stroke). Observation during the interview revealed R8 became visibly angry when discussing R39 taking his tobacco. During interview on 02/25/2025 at 10:27 AM, Registered Nurse (RN) 1 stated she witnessed the incident between R8 and R39 on 09/22/2025. She stated R8 had been wheeling down the hall and R39 was wheeling behind him yelling at R8. The RN reported she saw R8 grab R39's arm and wheelchair nearly tipping the wheelchair over, and staff intervened. RN 1 further stated three cans of smokeless tobacco had been tucked under R39's leg in the wheelchair. She additionally stated R39 had been moved to a room on a different hall, and R8 had been placed on 1:1 supervision. During interview on 02/26/2025 at 12:30 PM, Licensed Practical Nurse (LPN) 1 stated she was the nurse for the hall R39 resided on. She stated R39 wandered through the facility all the time via his wheelchair. The LPN stated if R39 was seen in an area where he should not be located, such as other residents' rooms, he was redirected by staff. She said no specific orders were noted for R8 for increased supervision; however, all residents should be checked on hourly. LPN 1 further stated there was no specific order or documentation to increase supervision for R39, however she stated the information to increase monitoring for R39 due to his wondering had been passed along in report at shift change. During interview on 02/26/2025 at 1:15 PM, the Social Services Director (SSD) stated she was aware of the incident between R8 and R39, and that R8 alleged R39 had stolen his cigarettes. She said she completed conflict resolution with R39 and R8. The SSD stated anytime R39 was observed in areas where he should not be, or attempting to go into other residents' rooms R39 was to be redirected. During interview on 02/26/2025 at 3:30 PM, State Registered Nursing Assistant (SRNA) 9 stated she often redirected R39 if she saw him in areas he should not be in. She further stated there was no specific order for increased supervision of R39 but it was passed along in report at shift change to redirect R39 if he was wandering in other residents' rooms. During interview on 02/27/2025 at 9:25 AM, the Administrator stated she remembered the incident that occurred involving R8 and R39. She reported she understood it was cigarettes that R39 was upset about during the incident, and he was informed his cigarettes were locked up at the facility. The Administrator further stated R39 had an ankle alarm on and had been placed on 1:1 supervision while the facility investigated the incident. In addition, she stated R39 had been moved to another hall.