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	04/16/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview, record review, and review of facility policy, the facility failed to provide medications in a timely manner to treat a Urinary Tract Infection (UTI) for 1of 38 sampled residents, Resident (R)117. R117 developed a UTI and Fosfomycin 3 grams as a single-dose treatment (antibiotic) was ordered on 11/11/2026 at 11:28 AM. However, the medication was not administered until 11/15/2025 at 4:23 PM, 4 days later. The resident experienced pain and discomfort.The findings include: Review of the facility's policy titled, Medication ordering and receiving from Pharmacy, dated November 2021, revealed the Administrator, Director of Nursing, and dispensing pharmacy established a daily delivery and pick-up schedule for medication orders. Review of R117's Face Sheet revealed the facility admitted the resident on 10/27/2022. R117's diagnoses included arthropathic psoriasis, and morbid obesity. Review of R117's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/24/2025, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 15 out of 15. This score indicated intact cognition. Review of R117's Comprehensive Care Plan, revealed a focus for elimination deficit related to impaired mobility, contracture of the left knee, morbid obesity, and myalgia last revised on 01/23/2026. The interventions included: straight catheter as needed for urinalysis, and monitor for signs and symptoms of urinary tract infection. Review of R117's Primary Acute Note, dated 11/07/2025 at 12:01 PM, written by Nurse Practitioner (NP)1, revealed R117 was seen due to a fever of 102 degrees Fahrenheit overnight. Review of the Primary Follow-Up Note, dated 11/11/2025 at 12:00 PM, written by NP1, revealed in reference to the urinalysis completed on 11/07/2025, Out of abundance of caution would give Fosfomycin [A broad-spectrum antibiotic used as a single-dose treatment for uncomplicated lower urinary tract infections. It works by inhibiting bacterial cell wall synthesis] 3 g [grams] x1 dose since it had Extended Spectrum Beta Lactamase (ESBL) coverage while waiting on culture given +Leukocytes and +Nitrites on UA. Review of the urinalysis results, dated 11/07/2025, revealed Leukocytes 3+, Bacteria 3+, [NAME] Blood Cells too numerous to count (tntc). A urinalysis reflex culture (two step diagnostic process where a laboratory automatically performs a urine culture only if the initial urinalysis shows abnormal results) completed on 11/07/2025 for a clean catch urine was negative. The facility signed as receiving the results on 11/12/2025. Review of R117's Medication Administration Record (MAR), revealed orders for Fosfomycin Tromethamine Oral Packet three grams, one time by mouth, for Urinary Tract Infection (UTI) with a start date of 11/12/2025. A new entry on the MAR, dated 11/13/2025 at 8:43 AM, revealed instructions to hold the medication due to not being available from pharmacy; however, there was no documented evidence of a physician's order to hold the medication. Further review of the MAR. revealed a 'new entry for the Fosfomycin with a start date of 11/15/2025. Per the MAR, the medication was documented as administered on 11/15/2025 at 4:23 PM. Review of the Hospital Emergency Department (ED) Discharge Note, dated 11/24/2026, revealed R117 was transferred to the ED with a diagnosis of complicated UTI. R117 received Rocephin 1000 milligrams (mg) intramuscular (IM) injection (antibiotic), and Toradol 15 mg/milliliter IM for pain. The resident was discharged on 11/25/2026 at 209 AM. During an interview on 04/15/2026 at 11:30 AM with R117, she stated in (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	November of 2025 she developed a Urinary Tract Infection (UTI) and had gone without treatment for approximately three weeks. She further stated Nurse Practitioner 1 had placed an order for an antibiotic that was a one-time dose back in November of 2025 and she never received the antibiotic. In additional interview, R117 stated she eventually ended up going to the Emergency Department (ED) due to high fever and was diagnosed with a urinary tract infection (UTI).Attempted to contact Licensed Practical Nurse (LPN)11 on 04/16/2026 at 4:38 PM, who had documented medication not available on 11/13/2025. However, no return call was received after leaving a message.During an interview on 04/16/2026 at 9:44 AM with the Infection Preventionist (IP) he stated when an antibiotic was ordered, the facility followed the McGreer criteria which is a standardized surveillance definition used in long-term care facilities to detect infections. The primary purpose for the McGreer criteria is to distinguish infection from colonization in nursing homes. Furthermore, when a urinalysis was ordered and did not meet the criteria for an antibiotic, the physician was contacted and made aware if changes needed. He stated he was not aware of the incident with R117 but stated the urinalysis did not meet the McGreer criteria. During an interview on 04/16/2026 at 3:55 PM, with the Director of Nursing (DON), she stated she was not sure why the Fosfomycin was not given on 11/11/2025 as ordered by NP1. She stated this was a medication that was used often in the facility and had been readily available from the pharmacy. The DON further stated if the Pharmacy did not have the ordered medication or if there was a delay in getting the ordered medication, the facility should have contacted the ordering provider and obtained an order for a comparable medication. Additionally, the DON stated the facility did not keep Fosfomycin antibiotic in the Emergency Medication Supply. Further, the DON stated it was her expectation medications were received timely from the pharmacy and administered to the resident. Furthermore, the DON stated there should have been documentation in the progress note explaining any delay with receiving medications and who was contacted. She further stated any delay in antibiotics could possibly lead to sepsis and pain.During an interview on 04/16/2026 at 2:25 PM with the Administrator, she stated her expectation was the policies be followed by all staff.