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	04/05/2024

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

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45113 Based on interview, record review, and review of the facility's policies, it was determined the facility failed to ensure residents were free from misappropriation of property. Controlled substances/medications were misappropriated without authorization from eight (Resident (R) 4, R10, R11, R13, R45, R78, R86 and R90) of 89 sampled residents. The findings include: Review of the facility's undated policy titled, Resident Rights, revealed each resident had the right to receive treatment and supports for daily living safely. Per the policy, the facility shall exercise reasonable care for the protection of the resident's property from loss or theft. Review of the facility's policy titled, Resident Protection Plan, dated 09/15/2022, revealed each resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy revealed Misappropriation of property was defined as deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings without the resident's consent. Review of the facility's policy titled, Master Control Log for Scheduled Drugs Sheet, last revision 06/2011, revealed a master control log would be utilized for all controlled drugs in the facility. The procedures indicated during narcotic count, the nurse would verify the count sheets matched the Master Control Log before accepting the narcotic keys. In addition, daily, the Director of Nursing (DON) would make a copy of the master Control Log to be maintained in a notebook in their office. However, the policy did not provide the procedure for controlled substance shift count, discrepancies and/or proper security procedures of narcotic keys. Review of a facility investigation revealed an investigation was initiated on 03/17/2024 at 9:50 PM. Staff interviews revealed that on 03/17/2024, there was reasonable suspicion that Licensed Practical Nurse (LPN) 1 was under the influence and, as a result, was removed from taking care of residents. LPN1 agreed to a drug screen and was suspended. As part of the investigation, interviewable residents on the hall assigned to LPN 1 were asked by the DON if they had received their medication. Although some residents could not remember for sure, others said no, they had not. (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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the facility investigation, narcotic count and cart counts were checked twice by the DON and Registered Nurse (RN)1. The investigation found that the narcotic count was accurate when LPN1 accepted the medication cart at the beginning of first shift on 03/17/2024. However, the Controlled Drug Count and cart review conducted on 03/17/2024 at approximately 6:30 PM (in response to the allegations against LPN1), revealed 12 narcotics/controlled substance medications were now unaccounted for and missing without a signature to indicate that they had been signed out for administration. The controlled drug reconciliation sheet revealed the following missing medications: a. R4 was missing one hydrocodone/APAP (Norco-a narcotic opioid used to treat pain) 5/325 milligram (mg) tablet, and one Lorazepam (Ativan - a benzodiazepine used to treat anxiety) 0.5 mg tablet. b. R10 was missing one hydrocodone/APAP 5/325 mg tablet, and one clonazepam (a benzodiazepine used to treat anxiety) 1 mg tablet. c. R11 was missing one gabapentin (Neurontin-a narcotic used to treat nerve pain) 600 mg tablet. d. R13 was missing one gabapentin 600 mg tablet. e. R45 was missing one clonazepam 0.5 mg tablet. f. R78 was missing one hydrocodone/APAP 5/323 mg tablet, and one alprazolam (a benzodiazepine used to treat anxiety and panic disorder) 0.5 mg tablet. g. R86 was missing one dronabinol (Marinol-a cannabinoid used to control nausea and vomiting) 10 mg. h. R90 was missing two gabapentin 100 mg tablets. Interviews with residents whose medications were missing included: a. Review of R10's Quarterly Minimum Data Set (MDS) assessment, dated 02/06/2024, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 14/15, indicating resident was cognitively intact. During an interview with R10 on 04/01/2024 at 12:20 PM, the resident recalled not receiving pain medication all day but did not experience any issues of uncontrolled pain. b. Review of R13's Quarterly MDS assessment, dated 03/14/2024, revealed the facility assessed the resident to have a BIMS score of 13/15, indicating the resident was cognitively intact. During an interview with R13 on 04/01/2024 at 1:25 PM, the resident stated, No, I did not get my Neurontin that morning. The resident said they had not experienced any issues with medication administration, such as not receiving narcotic medications, prior to the incident. c. Review of R78's Quarterly MDS assessment, dated 02/13/2024, revealed the facility assessed the resident to have a BIMS score of 10/15, indicating the resident was moderately impaired in cognition. During an interview with R78 on 04/01/2024 at 1:50 PM, the resident stated, No, I don't think I got my pain medication that day. R88 stated they were shocked regarding the misappropriation of their medication. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Review of R86's Annual MDS assessment, dated 01/15/2024, revealed the facility assessed the resident to have a BIMS score of 15/15, indicating the resident was cognitively intact. During an interview with R86 on 04/01/2024 at 2:10 PM, the resident stated, I had taken a nap earlier in the day, but I'm pretty sure that I did not get my Marinol. e. Review of R90's Quarterly MDS assessment, dated 02/27/2024, revealed the facility assessed the resident to have a BIMS score of 15/15, indicating the resident was cognitively intact. During an interview with R90 on 04/01/2024 at 2:36 PM, the resident stated, No, I did not get my pain medication [Neurontin] that morning. The State Survey Agent (SSA) attempted a telephonic interview with LPN1, on 03/29/2024 at 2:55 PM and again on 03/30/2024 at 9:45 AM. LPN1 did not answer or return the surveyor's call. During an interview on 04/05/2024 at 2:28 PM, State Registered Nurse Aide (SRNA) 6 stated that at approximately 3:30 PM on 03/17/2024, they noticed something was not right. LPN1 was observed falling asleep at the nurse's station and slumped over the medication cart. During an interview on 04/05/2024 at 2:36 PM, with SRNA13, she stated on 03/17/2024 at approximately 4:30 - 5:00 PM, she observed LPN1 dozing off at the nurses' station and stated that when staff asked LPN1 if she was okay, she would eventually respond, back hurting. SRNA13 added that during evening medication pass, she observed LPN1 standing at the med room door, jiggling the doorknob, and then fidgeting in her pocket with keys for at least thirty (30) minutes. However, she added, LPN1 never entered nor tried to use the keys to open the med room door during this time. During an interview on 04/05/2024 at 2:16 PM with Kentucky Medication Aide (KMA) 2, she stated that at approximately 4:30 PM, around last med pass, something was wrong with LPN1, who could not comprehend, and just stood there in a daze and could hardly hold herself up. KMA2 stated she was concerned for the residents because a staff with an impaired judgement could cause a detrimental resident outcome. KMA2 stated none of the staff felt comfortable performing a narcotic count, because of the unknown outcome related to LPN1 ' s appearance and actions. KMA2 was not aware of the facility policy/procedure related to narcotic count and/or taking over of narcotic keys with a staff involved in this type of situation. During an interview on 04/04/2024 at 1:38 PM, LPN2 stated she worked as the Unit Coordinator on 03/17/2024 at approximately 10:20 AM and observed LPN1 on their first break, with normal appearance and clear speech. However, at approximately 4:30 PM, staff approached LPN2, saying that LPN1 was acting inappropriately, was under the influence, and was unable to perform work duties. LPN1 was observed passing out and asleep on her med cart. LPN2 contacted the Administrator and informed her of staff concerns and was instructed to remove LPN1 from resident care. LPN2 stated LPN1 was not coherent enough to count narcotics, let alone provide safe and adequate care to residents. During an interview on 03/22/2024 at 2:00 PM, RN4 stated that when she saw LPN1 at 3:00 PM, she contacted the Administrator immediately related to LPN1's appearance and actions. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/29/2024 at 11:00 AM. the DON stated that on 03/17/2024 at approximately 4:50 PM, she was notified by telephone per the Administrator regarding staff concerns related to LPN1 ' s behavior and was informed of the urgency to get to the facility, ensure resident safety and the immediacy to initiate an investigation. The DON stated on her arrival to the facility, she observed LPN1 sitting outside at the smoke [NAME], slumped over on her knees with eyes closed and slow to respond. The DON stated LPN1 had just been released from her primary physician to return to work duties related to a back injury, and LPN1 admitted to the DON that she had taken a self-prescribed narcotic earlier in the week. However, per the DON, LPN1 was never asked about the misappropriation of resident narcotic medications. The DON stated LPN1 informed her that she had completed the evening medication pass but had not signed off the medications. However, resident interviews and review of the facility's investigation revealed the residents stated they did not receive their medications. The DON stated, that after conducting the investigation, the facility found that LPN1 failed to ensure residents were free from misappropriation of property and the diversion of their medications. Per the DON, LPN1 was terminated after failing to promote a safe comfortable environment for all residents and for violation of facility policies. Interview with the Administrator on 04/03/2024 at 9:46 AM revealed her expectation was that each nurse must perform a narcotic count with the off-going nurse before their shift and prior to possession of the narcotic cart keys. During an additional interview on 04/05/2024 at 2:25 PM with the Administrator, she stated LPN1 was removed from resident care immediately upon staff notification of the LPN's apparent impairment and inability to perform work duties. The Administrator stated the Interdisciplinary Team (IDT) decided prior to receipt of LPN 1's drug screen results, that the facility would not continue her employment, based on residents not receiving their medication. The Administrator stated her expectation of all nursing staff, specifically with the administration of medications would be to follow the facility's policies and procedures related to Resident Rights policy, and Freedom from Misappropriation policy. Review of the facility's Employee File for LPN1 revealed a hire date of 01/12/2021. The Screening Report/State Criminal background checks, dated 01/13/2021 and 07/15/2023, revealed a cleared status for employment. LPN1 had a Kentucky Board of Nursing (KBN) validation, dated 03/20/2024, which showed a valid/current licensure, with no restrictions on the license. Further review of the employee file revealed a Negative urine drug screen result, dated 03/20/2024. An employee Termination Form dated 03/22/2024, noted the LPN was terminated related to standards of conduct violation. Additionally, LPN1's employee file revealed a letter of receipt from the KBN, addressed to the facility, with a subpoena record request, dated 03/20/2024, which noted acknowledgement of receipt of information submitted regarding the allegation of Missing Narcotics and nursing practice by LPN1.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 44000 Based on observation, interview, record review, manufacturer ' s recommendations, and review of the facility's policy, it was determined the facility failed to ensure it was free of a medication error rate of five percent or greater. During the medication pass observation of 69 opportunities for administration of medication, there were nine opportunities in which medications were not administered according to manufacturer ' s recommendations and/or the facility ' s medication policy, resulting in an error rate of 13. 04%. The failure affected two (Resident (R) 25 and R113) of 19 sampled residents. R25 ' s insulin injection was not prepared correctly and R113 failed to receive the full value of eight crushed medications. The findings include: 1. Review of the manufacturer's recommendations for Tresiba insulin, dated 07/2022, revealed the insulin should not be removed from its flex pen by using a syringe. This could cause an incorrect dose resulting in low or high glucose (blood sugar). Review of R25's medical record revealed the resident had diagnoses including diabetes and chronic kidney disease. Review of R25's Comprehensive Care Plan (CCP), initiated on 02/15/2024, revealed the resident was at risk for hyperglycemia (elevated blood sugar) and hypoglycemia (low blood sugar.) Interventions included for staff to administer diabetic medications as ordered by the medical doctor. Review of R25's Physician's Orders, dated 03/26/2023, revealed an order for Tresiba (insulin), inject 22 units subcutaneously two times a day for diabetes Mellitus. Review of R25's Medication Administration Record (MAR) dated 03/01/2024 to 03/31/2024 and 04/01/2024 revealed R25 received 22 units of Tresiba twice a day as ordered. Observation during medication pass on 04/02/2024 at 9:25 AM revealed Licensed Practical Nurse (LPN) 3 removed the cap from the Tresiba flex pen and wiped the tip with an alcohol pad. She then pulled up the insulin from the prefilled Tresiba flex pen using a regular insulin syringe (rather than an adaptor designed for use with the flex pen.) LPN3 next knocked on R25's door and went in to administer the medication to R25. Although LPN3 was prepared to administer the medication, R25 refused the insulin and told LPN3 that they took the long-acting insulin at a different time. LPN3 then called the physician and left a message that R25 refused the morning insulin. During an interview with LPN3 on 04/02/2024 at 9:30 AM, she stated she cleaned the prefilled syringe site with an alcohol wipe to prevent the spread of infection. LPN3 stated she knew there were special adapters for use with the prefilled flex pens, but she did not have any of those on her medication cart and was not aware of where to go to get the special adapters. LPN3 stated she was not aware she could not use a syringe to pull up insulin from an insulin pen and was unaware of possible adverse reactions, including hypoglycemia, related to using a syringe to draw up the insulin from a flex pen. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the Director of Nursing (DON) on 04/04/2024 at 9:25 AM, she stated staff were educated in orientation to use the needle that goes with the flex pen to administer insulin. She further stated that she was not aware of any staff drawing up insulin from the flex pens using a syringe. She stated she expected nursing staff to always administer medications properly per the physician orders, facility policies, and best practice. Continued interviewed revealed the proper technique for administering insulin from a flex pen was to use the needle adapters that go with the flex pen. During an interview with Pharmacist (RPh)1 on 04/04/2024 at 10:17 AM, he stated Tresiba should only be administered using the needle adapters for the flex pens. If a syringe were used, an incorrect dose could occur, causing the resident to experience an adverse reaction. During interview with the Administrator on 04/05/2024 at 4:22 PM, she stated she expected staff to follow established policies related to medication administration. 2. Review of the facility's policy, titled, MedWiz, dated 11/2021, revealed that when medications are crushed for oral administration and placed in food, the entire content of the food must be consumed to assure the entire dose of medication has been consumed. Review of R113's Physician's Orders, dated 02/19/2024, revealed orders included: a. Omeprazole 40 milligrams (mg), give one capsule by mouth two times a day for Gastro/esophageal reflux disease (GERD). b. Metoprolol 50 mg give one tablet by mouth two times a day for hypertension. c. Sertraline 50 mg give two tablets by mouth one time a day for mood stabilizer. d. Irbesartan 300 mg give one tablet by mouth one time a day for hypertension. e. Divalproex 125 mg give one tablet by mouth one time a day for mood stabilizer. f. Fexofenadine 180 mg give one tablet by mouth one time a day for allergies. g. Sennosides 25 mg give one tablet by mouth one time a day for bowel care. h. Multivitamin Tablet give one tablet by mouth one time a day for supplement. Further review of R113's orders, dated 09/15/2023, revealed that staff May crush medications (or open capsules) as indicated per pharmacy protocol. Observation on 04/03/2024 at 8:45 AM revealed LPN3 crushed the eight ordered medications in a small plastic bag. She then scooped up applesauce, put it in a 30 milliliter (ml) plastic cup, poured the crushed medications into the cup, and stirred the medications. LPN3 then went into R113's room and explained she had the resident's medications. She then placed the spoon with the crushed medications into R113's mouth. The resident closed their mouth and swallowed applesauce with the medications mixed in it. LPN3 then removed the spoon, which still contained approximately 25 % (percent) of the crushed medications and applesauce from the resident ' s mouth. LPN3 put the spoon back in the cup and then threw it in the trash container located next to the resident's bed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with LPN3 at the time of the observation on 04/03/2024 at 8:45 AM, she said she thought R113 received all the medications and stated that failure to receive all the medication as ordered could result in a bad health outcome. When the surveyor asked LPN3 to check the medications in the trash can, LPN3 looked and stated there could be some medications left in the cup. LPN3 then continued with the medication pass without ensuring that the resident received all of the quantity of each of the eight medications ordered. During interview with the DON on 04/04/2024 at 9:25 AM, she stated staff were educated in orientation on administering crushed medications. She further stated staff should follow the facility policy and assure that all the medications that are crushed are taken by the resident. She also stated she was not aware of a staff member not giving all the crushed medications. During interview with the Administrator on 04/05/2024 at 4:22 PM, she stated she expected the DON to assure that the staff were following the facility's policies. 49360