

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185200	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2025
NAME OF PROVIDER OR SUPPLIER  Letcher Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47852</b></p> <p>Based on interview, record review, and review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Manual, the facility failed to electronically transmit the discharge assessment within 14 days as required for 1 of 31 sampled residents, (Resident (R)82).</p> <p>R82 was discharged on [DATE]; however, the resident's Discharge Minimum Data Set (MDS) Assessment was not transmitted as of 02/27/2025.</p> <p>The findings include:</p> <p>Review of the CMS RAI Manual, dated 10/2024, revealed the MDS completion date must be no later than 14 days for a Discharge Assessment, whether return anticipated or not anticipated. Further review of the RAI Manual revealed the MDS Assessment should be submitted within 14 days of the completion date.</p> <p>Review of R82's Face Sheet revealed the facility admitted the resident on 08/28/2024, with diagnoses which included muscle wasting and atrophy, chronic kidney disease, anxiety, and anemia.</p> <p>Review of R82's electronic medical record (EMR) revealed the last documented MDS Assessment had an ARD of 10/07/2024, noting discharge return anticipated. Per review, the MDS assessment dated [DATE], revealed it had been signed by the MDS Coordinator on 10/10/2024 as verification that the assessment had been completed. However, review further revealed the MDS Assessment was listed as Exported but not Accepted, which indicated the MDS had not been transmitted and accepted as required by the RAI guidelines.</p> <p>In interview with MDS Nurse 1 and MDS Nurse 2, on 02/27/2025 at 10:17 AM, they stated it was important to follow the guidelines in the (CMS) RAI Manual for transmitting a MDS Assessment for tracking purposes. The two MDS Nurses further stated R82's Discharge MDS Assessment should have been transmitted within 14 days of R82's discharge date of [DATE], as required. They additionally stated R82's MDS Assessment would be transmitted on 02/27/2025. They further stated that it had not been transmitted due to an oversight.</p> <p>In interview with the Administrator on 02/27/2025 at 3:25 PM, she stated she expected her MDS staff to complete and transmit a discharged resident's Assessment timely, according to the RAI Manual.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>47852</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to develop and/or implement a comprehensive person-centered care plan to meet the needs of 1 of 31 sampled residents, (Resident (R) 88).</p> <p>R88 was noted to have numerous refusals of wound care; however, the facility failed to develop the resident's comprehensive care plan to address her refusals</p> <p>The findings include:</p> <p>Review of the facility policy, Care Plan- Comprehensive H5MAPL0110, dated 09/2022, revealed the facility was to develop an individualized comprehensive care plan for each resident to meet the resident's medical, nursing, mental, and psychosocial needs. Continued review revealed each resident's comprehensive care plan was to incorporate identified problem areas, incorporate risk factors associated with identified problems, and reflect the resident's expressed wishes regarding care and treatment goals. Further review revealed assessments of residents were to be ongoing and care plans were to be revised as information about the resident and the resident's condition changed.</p> <p>Review of R88's electronic medical record (EMR) revealed the facility admitted the resident on 09/03/2024, with diagnoses that included osteoarthritis, difficulty in walking, and muscle wasting and atrophy.</p> <p>Review of R88's Comprehensive Care Plan revealed the facility identified a problem for alteration in skin integrity with a deep tissue injury (DTI) to the coccyx on 11/15/2024. Continued review revealed the facility assessed the pressure ulcer to R88's coccyx as a stage three. Further review revealed the interventions included: providing treatment as ordered; and to monitor the area to the coccyx for signs and symptoms of infection, decline, or improvement. Additionally, the review revealed the interventions included to notify the physician of any change every shift for wound care.</p> <p>Review R88's physician's orders revealed an order, dated 11/21/2024, to clean the pressure ulcer to the resident's coccyx with normal saline, pat dry, apply collagen particles to the wound bed, and cover with a bordered gauze dressing every day shift.</p> <p>Observation, on 02/26/2027 at 2:30 PM, revealed R88 had a bariatric bed. Further review of R88's physician's orders revealed no documented evidence of an order for a specialty air mattress. In addition, further review of R88's alteration in skin integrity care plan revealed no documented evidence that a specialty air mattress had been ordered or a care plan developed to address an intervention for a specialty mattress to assist with healing of the pressure ulcer.</p> <p>Review of R88's February 2025 Medication Administration Record/Treatment Administration Record (MAR/TAR) revealed the resident refused wound care to her coccyx on 02/01/2025, 02/09/2025, 02/19/2025, 02/22/2025, 02/25/2025, and 02/26/2025.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R88's Progress Notes revealed the resident refused wound care to her coccyx on 02/22/2025, 02/25/2025, 02/26/2025 and 02/27/2025.</p> <p>Review of Advanced Practice Registered Nurse (APRN) 1's note, dated 02/18/2025, revealed R88 was noncompliant with wound care.</p> <p>Observation, on 02/26/2025 at 2:30 PM and 02/27/2025 at 10:30 AM, revealed R88 refused wound care to her coccyx.</p> <p>Further review of R88's Comprehensive Care Plan revealed no documented evidence the facility had care planned the resident's refusals or noncompliance with wound care to her coccyx.</p> <p>During interview with R88, on 02/26/2025 at 10:05 AM, she stated she did not feel well and did not wish to have the wound care done on that date. She further stated she had not allowed the wound care to be performed on 02/25/2025.</p> <p>During interview with MDS Coordinator 1, on 02/27/2025 at 10:17 AM, she stated behavior comprehensive care plans related to the residents refusal of wound care were completed by an MDS Nurse or the Social Services Director (SSD). She stated it was important to write a care plan to determine what interventions had been attempted and the effectiveness of those interventions regarding the resident allowing wound care. She further stated the comprehensive care plan was a guide for staff to know how to take care of residents.</p> <p>During interview with MDS Coordinator 2, also on 02/27/2025 at 10:17 AM, she stated wound care refusals should be care planned to show the different interventions attempted to encourage the resident to allow wound care in order to keep the wound from getting worse.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51157</p> <p>Based on observation, interview, and review of the facility's policy, it was determined the facility failed to prepare and serve food in a sanitary manner and in accordance with professional standards for food service safety.</p> <p>Observation of a test tray on 02/25/2025, with the Dietary Manager (DM) and Dietary Aide (DA) 1 revealed hot food temperatures (temps) were below 130 degrees Fahrenheit (F), and cold food items were above 41 degrees F. The failure had the potential to affect all residents of the facility who consumed food prepared in the kitchen.</p> <p>The findings include:</p> <p>Review of the facility's, Timely Meal Service policy, undated, revealed food was to be delivered promptly to assure safe, palatable, and high-quality food served at the proper temperature. Continued review revealed food was to be served at preferable temperatures (hot food hot and cold foods cold) as discerned by the residents and customary practice.</p> <p>Review of the facility's, Food Temperatures policy, undated, revealed all hot items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees F. Per policy review, hot food items must not fall below 135 degrees F after cooking. Further review of the policy revealed all cold food items must be stored and served at a temperature of 41 degrees F or below.</p> <p>1. Observation during a routine test tray temperature (temp) check on 02/25/2025 at 1:05 PM, revealed the food items were not within the required temperature standards, with hot foods below the required 135 degrees F, and cold food/drink above the required 41 degrees F or below. Per observation, the turkey was temped at 102.5 degrees F, mashed potatoes 129.7 degrees F, carrots 110.9 degrees F, and milk 43.7 degrees F.</p> <p>During interview on 02/25/2025 at 1:09 PM, the DM stated the meal service times were normal, and she was not sure what caused the food temperatures to be out of range.</p> <p>2. Observation on 02/24/2025 at 4:00 PM; 02/25/2025 at 11:40 AM; and 02/26/2025 at 9:20 AM, revealed two stacks of plates sitting on the hot bar outside of the plate warmer. Continued observation revealed dietary staff removed stacks of plates from the plate warmer and placed them on the hot bar for use in the meal tray line.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 02/26/2025 at 9:25 AM, the DM stated the plate warmer was not big enough to hold all the plates the facility used during meal service. The DM reported the cooks who were serving food pulled several plates from the warmer and stacked them on the side of the hot bar, allowing them to cool. In continued interview the DM said she felt the plates not being warm was the issue for the reduced temperatures of food items being served. The DM stated that if residents were served food items outside of the safe temperature range, it could lead to food poisoning, making the residents sick. The DM further stated it was important to serve residents foods at the right temperatures to give them a homelike experience.</p> <p>During interview on 02/27/2025 at 3:25 PM, the Administrator stated serving food outside of the safe handling zone could cause salmonella, gastrointestinal (GI) symptoms, food poisoning, or other illnesses. The Administrator said it was her expectation for warm foods to be served warm and cold foods to be cold. The Administrator further stated she wanted the food served to residents to be warm and something the residents enjoyed eating.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>47852</p> <p>Based on observation, interview, record review, and review of the facility's policy, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 4 of 31 sampled residents, (Resident (R)37, R95, R100, and R113).</p> <p>The findings include:</p> <p>Review of the facility's policy, Infection Prevention Program Overview, undated, revealed the goals of the infection prevention program were to decrease the risk of infection to residents. Per review, the goals also included maintaining compliance with state and federal regulations relating to infection prevention. Further review revealed the prevention of spread of infections was accomplished by use of hand hygiene, standard precautions and other barriers, and appropriate treatment and follow-up.</p> <p>Review of the facility's policy, Oxygen Use, revealed the oxygen tubing was to be kept off the floor.</p> <p>1. Review of R37's Admission Record revealed the facility admitted the resident on 03/21/2022, with diagnoses which included diabetes, muscle weakness, and overactive bladder.</p> <p>Observation on 02/24/2025 at 4:00 PM, and on 02/27/2025 at 1:54 PM, revealed opened packages of adult protective briefs and individual briefs lying on the bathroom floor of R37's room.</p> <p>2. Review of R95's Admission Record revealed the facility admitted the resident on 10/11/2024, with diagnoses which included diabetes, muscle wasting, and chronic kidney disease.</p> <p>Observation on 02/24/2025 at 4:20 PM, revealed R95's oxygen nasal cannula lying on the floor uncovered. Further observation revealed R95's nebulizer tubing lying on the resident's bedside table uncovered.</p> <p>3. Review of R100's Admission Record revealed the facility admitted the resident on 07/19/2024, with diagnoses which included diabetes, malignant neoplasm of the colon, and chronic obstructive pulmonary disease.</p> <p>Observation on 02/27/2025 at 1:54 PM, revealed opened packages of briefs and individual briefs lying on the bathroom floor of R100's room.</p> <p>4. Review of R113's Admission Record revealed the facility admitted the resident on 11/25/2024, with diagnoses which included malnutrition, lack of coordination, and muscle wasting.</p> <p>Observation on 02/24/2025 at 4:25 PM, revealed R113's nebulizer tubing lying on R113's beside table uncovered.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 02/27/2025 at 1:15 PM, the Infection Preventionist (IP) stated oxygen and nebulizer tubing should be stored in bags when not in use to prevent bacteria from growing and traveling into the resident's lungs. He said the tubing should not be dropped on the floor and then used for the resident as the tubing would have germs on it. The IP stated residents' incontinent supplies should be kept in the residents' closets or dressers and not left lying on the residents' bathroom floors or stored under the bathroom sink because that was a damp, dark place and you don't know what's growing. He additionally stated residents' individual briefs were to be thrown away because it was unknown what they (briefs) had touched, and therefore, could be a source of infection. The IP further stated residents' rooms should be checked every shift to ensure their briefs were stored appropriately in closets and dressers.</p> <p>During interview on 02/27/2025 at 3:25 PM, the Administrator stated incontinent supplies were to be kept in the resident's closet or bedside table and should never be left lying on the bathroom floor or under the bathroom sink. She stated the incontinent supplies in the bathroom floor would be an infection control issue and could cause the resident to have an infection. The Administrator further stated she expected staff to check the residents' rooms every two (2) hours and not allow incontinent supplies to be left lying on the floor.</p>		