STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185221	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salyersville Nursing and Rehabilitation Center	662 Parkway Drive Salyersville, KY 41465

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to immediately inform the resident's physician and/or Responsible Party (RP) as required for one (Resident (R) 1) of nine residents reviewed for medication administration. R1's Vimpat (an anti-convulsant medication used to treat seizures) was unavailable and not administered from 01/29/2026 until 02/01/2026. When the evening dose of Vimpat was administered on 02/01/2026, R1 received twice the ordered dose. The facility failed to immediately notify the resident's physician and representative of these medication errors. In addition, the facility failed to immediately notify the resident's RP when the resident was transferred to the hospital for evaluation after the 02/01/2026 medication overdose resulted in a change of condition.The findings include:Review of the facility's protocol, Medication Error Standard of Practice, dated 04/2025, revealed the purpose was to provide a timely response to identified medication administration errors. Further review revealed it was the facility's protocol upon suspected/identified resident medication administration error; the administering nurse or medication aide should immediately alert the Director of Nursing (DON) and/or charge nurse for physician notification. Review of R1's Care Plan Report revealed the facility admitted R1 on 01/29/2026 with diagnoses which included acute and chronic respiratory failure with hypoxia, anoxic brain damage, and severe intellectual disabilities. Review of R1 s admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) 01/31/2026, also revealed the resident had a diagnosis of seizure disorder. a. Review of physician orders, dated 01/29/2026, revealed an order for Vimpat 100 milligrams (mg) twice daily. R1 also had orders for an additional anti-seizure medication, Zonisamide 200mg, on a daily basis. However, review of R1 s Medication Administration Record (MAR) for 01/2026 and 02/2026 revealed R1's Vimpat was marked as not available/not administered on 01/29/2026, 01/30/2026, and 01/31/2026 for either morning or evening dose. Further review revealed R1 s Vimpat was also not given on the 02/01/2026 morning dose. (Refer to F760.) There was no evidence that the facility notified the physician that the anti-seizure medication was not available and not being administered during this time. b. Review of an 02/02/2026 Medication Variance Form, (used to document medication errors) and the facility's investigation report revealed that Licensed Practical Nurse (LPN) 1 administered R1 200mg of Vimpat, rather than the 100mg ordered. Per a late entry Progress Note for 02/01/2026, the facility investigation, and a review of a hospital report, dated 02/02/2026, R1 was transferred to the hospital for evaluation of a medication overdose, after showing a significant change in condition. (Refer to F760.) Further review of the 02/02/2026 Medication Variance Form revealed documentation that the physician was notified of this error on 02/01/2026 with no new orders, and the responsible party was notified on 02/02/2026. Although LPN1 documented physician notification of the medication error occurred on 02/01/2026 and RP notification on 02/02/2026, interviews with the physician and RP revealed that this was not accurate.During an interview on 02/11/2026 at 11:51 AM, R1's (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible party (RP1) stated she received a phone call from the hospital on [DATE] at 1:56 AM, informing her that R1 was sent to the hospital for a med error. She confirmed that, prior to the hospital's notification, no one from the facility called her to inform her that R1 was being transferred to the hospital for a change in condition. Further interview with RP1 revealed no one from the facility had ever notified her of R1 missing medications for multiple days or the medication error in which the resident received twice the ordered amount of Vimpat .During an interview, on 02/11/2026 at 12:10 PM, the Medical Director stated he would expect to be notified of every time a resident missed a dose of their seizure medication. He further stated he was never notified of R1 missing any medication. During an interview, on 02/12/2026 at 9:30 AM, Physician Assistant (PA) 1 stated she was not informed of R1 missing anti-seizure medication from 01/292/2026 - 02/01/2026. In addition, PA1 stated she was not immediately informed of the medication error which occurred at approximately 6:00 PM on 02/01/2026. PA1 stated she was unaware of any concerns with R1 until the 02/01/2026 call from the nurse around midnight stating she had trouble keeping R1's oxygen level up and R1 was drowsy with increased secretions. Interview on 02/10/2026 at 1:30 PM with LPN1 revealed conflicting information about the required notification. LPN1 stated she was called on 02/02/2026 and asked to come into the facility to complete a report on a medication error that occurred on 02/01/2026 when she accidentally popped two pills out instead of one, because I thought she got two. During this interview, LPN1 stated she was unaware she had made an error until she was called on 02/02/2026. LPN1 provided no explanation as to why she had documented MD/RP notification on 02/01/2026 (if she was not aware of the error until 02/02/2026.) Although LPN1 alleged she was unaware of the medication error until 02/02/2026, interviews with additional staff revealed that the facility was aware of the error on 02/01/2026 and indicated that the physician should have been immediately contacted. For example, during an interview on 02/12/2026 at 12:17 PM, LPN2 (the night nurse on 02/01/2026) stated LPN1 realized during shift change at 7PM on 02/01/2026 that she gave the wrong medication to R1. LPN2 stated she thought LPN1 would call the doctor and responsible party since she made the error and knew what occurred. During an interview on 02/12/2026 at 12:52 PM, the weekend supervisor stated he worked 7:00 AM to 7:00 PM on 02/01/2026 and was notified at the end of the shift by LPN1 that a medication error was made for R1 that was caught when LPN1 counted the narcotic cart with the oncoming nurse. He stated he expected LPN1 to call the provider and responsible party as she made the error. However, he stated he did not follow up to ensure that was done. During an interview on 02/12/2026 at 2:30 PM, the DON stated it was her expectation that any nurse who identified a medication error would immediately notify the physician and responsible party immediately.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to ensure one (Resident (R) 1) of nine residents reviewed for medication administration was free from significant medication errors. The facility failed to administer Vimpat (an anti-convulsant medication used to treat seizures) from 01/29/2026 until 02/01/2026, due to unavailability. When Licensed Practical Nurse (LPN) 1 administered the first (evening) dose of Vimpat on 02/01/2026, the resident received 200 milligrams (mg), rather than the 100 mg which was ordered. These errors are considered significant, as Vimpat has a narrow therapeutic window for safety, with high doses or incorrect administration having the potential to lead to increased seizures and/or severe, life-threatening events. After receiving twice the ordered dose, the resident became lethargic, displayed a change in condition, and required transfer to the hospital for evaluation in response to medication overdose. The findings include:Review of the facility's protocol, Medication Administration Standard of Practice, dated 04/2025, revealed Medications must be administered in accordance with the orders, including required time frame. Review of the facility's protocol, Medication Error Standard of Practice, dated 04/2025, revealed it was the facility's protocol upon suspected/identified resident medication administration that the administering nurse or medication aide should immediately alert the Director of Nursing and/or charge nurse for physician notification. Per the policy, the resident should be assessed for potential adverse reaction, with any change of condition reported to the physician. Additionally, the nurse should complete a Medication Variance Form to document the event detail, interventions, and notifications.Review of R1's Care Plan Report revealed the facility admitted R1 on 01/29/2026 with diagnoses which included acute and chronic respiratory failure with hypoxia, anoxic brain damage, and severe intellectual disabilities. Review of R1's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) 01/31/2026, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 0/15, indicating R1 had severe cognitive impairment. Further review of the MDS revealed the resident had a diagnosis of seizure disorder. a. Review of physician orders, dated 01/29/2026, revealed an order for Vimpat 100 milligrams (mg) twice daily. R1 also had orders for an additional anti-seizure medication, Zonisamide 200mg, on a daily basis. Review of R1's Medication Administration Record (MAR) for 01/2026 and 02/2026 revealed R1's Vimpat was marked as not available and was not administered on 01/29/2026, 01/30/2026, and 01/31/2026 for either morning or evening dose. Further review revealed R1 s Vimpat was also not available/administered for the 02/01/2026 morning dose. There was no evidence that the facility notified the physician that the anti-seizure medication was not available and not being administered as ordered during this time frame. (Refer to F580). 0n 02/01/2026, the Weekend Supervisor contacted the pharmacy for a Stat (immediate) delivery, and the medication was provided in time for the evening administration on 02/01/2026. b. Review of a Medication Variance Form (used to document medication errors) revealed that on 02/02/2026 at 12:35 PM, Licensed Practical Nurse (LPN) 1 documented an error which occurred on 02/01/2026 at 6:00 PM. Per the report, R1 was ordered 100 mg of an unidentified medication; however, the resident was administered a 200 mg dose. Investigation revealed that the unidentified medication error was administration of 200 mg of Vimpat, rather than 100mg (twice the prescribed dose.) Review of R1's Progress Notes revealed that on 02/04/2026, LPN2 made a late entry for 02/01/2026. Per the note, LPN2 sent R1 out to the hospital around 11:50 PM on 02/01/2026, as respiratory staff were concerned regarding R1's oxygen level at 88%-92%. Per notes, R1 was not herself, in an almost sedated state after the medication error at approximately 6:00 PM, when 200 mg of Vimpat was given, instead of R1's normal order of 100 mg. Review of R1's Investigation Interview Form, dated 02/02/2026 at 12:00 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PM, and signed by Unit Manager (UM) 1, revealed UM1 was working 11:00 PM to 7:00 AM (02/01 - 02/02/2026) shift, when a nurse (night shift) approached UM1 and informed her that the day shift nurse (LPN1) gave R1 a medication from a different blister pack of the same medication but a different dose. Further review revealed the night shift nurse said R1 seemed lethargic and had an increased amount of mucous with respiratory confirming an increased need for suctioning. Continued review revealed UM1 advised the nurse to contact the on-call provider and Director of Nursing (DON). Additionally, the on-call provider instructed the nurse to send R1 to the ED for evaluation. Review of R1's hospital Emergency Department (ED) Note, dated 02/02/2026 at 1:53 AM, revealed R1 was seen for a chief complaint of overdose and a stated complaint of overmedicated. Further review revealed R1 was transferred to the ED from the facility for an overdose of antiseizure medication. The resident was assessed, treated, and returned to the facility on [DATE] with no new orders.Further review of R1's Investigation Interview Form, dated 02/02/2026 at 12:00 PM, and signed by Registered Nurse (RN) 1, revealed RN1 spoke with LPN1 about the medication error and asked LPN1 (who was off shift) to return to the facility to complete an incident report on medication error. The form noted that LPN1 stated that meds were delivered from pharmacy and she was in a hurry and pulled meds from wrong blister pack. During an interview on 02/10/2026 at 1:30 PM, LPN1 stated she was called on 02/02/2026 and asked to come into the facility to complete a report on a medication error that occurred on 02/01/2026. LPN1 stated the error occurred when she accidentally popped two pills out instead of one, because I thought she got two. During this interview, LPN1 stated she was unaware she had made a medication error until she was called on 02/02/2026. Although LPN1 alleged she was unaware of the medication error until 02/02/2026, interviews with additional staff revealed that the facility was aware of the error on 02/01/2026. For example, during an interview, on 02/12/2026 at 12:17 PM, LPN2 (the night nurse on 02/01/2026) stated LPN1 realized during shift change at 7PM on 02/01/2026 that she gave the wrong medication to R1. LPN2 stated that the weekend supervisor was notified at the time the med error was discovered on 02/01/2026. Interview with LPN2 revealed that after the medication error occurred, R1 became more lethargic during the night and, in response, she called the on-call provider and sent the resident to the ED.During an interview on 02/12/2026 at 12:52 PM, the weekend supervisor stated he worked from 7:00 AM to 7:00 PM on 02/01/2026. He confirmed that LPN1 notified him at the end of the shift that a medication error was made for R1, and the error was caught when LPN1 counted the narcotic cart with the oncoming nurse. During an interview, on 02/11/2026 at 12:10 PM, the Medical Director stated he would expect the staff administering medications to verify they gave the correct medication. During an interview, on 02/12/2026 at 9:30 AM, Physician Assistant (PA) 1 stated she was on call the night of 02/01/2026 and received a call from the nurse around midnight. PA1 stated the nurse related she had trouble keeping R1's oxygen level up and R1 was drowsy with increased secretions, and, in response, she ordered the nurse to send R1 to the ED.During an interview, on 02/12/2026 at 2:30 PM, the DON stated it was her expectation that any nurse would follow physician orders. Although LPN1 described the error as occurring because she accidentally gave R1 two of her Vimpat tablets, interview with the DON revealed that this was not accurate. The DON provided narcotic count sheets and explained that the significant medication error occurred when LPN1 pulled a 200 mg Vimpat tablet from the supply belonging to R7 (a different resident) and administered it to R1, instead.