

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Salyersville Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's documentation and policy, the facility failed to ensure professional standards of nursing practice were maintained regarding the storage, tracking, and reconciliation of scheduled controlled substances for 1 of 1 residents sampled for narcotic medication out of the total sample of 10 (Resident (R)43). The findings include: Review of the facility's policy titled, Medication Administration Standards of Practice, last revised 03/2026, revealed the policy did not specifically address new narcotic medication security after delivery from the pharmacy. Review of the admission Face Sheet for R43 revealed the facility admitted the resident on 07/07/2026. According to review of the admission Face Sheet, the resident's medical history included diagnoses of left femoral neck fracture, muscle wasting and atrophy, and unspecified pain. Review of the admission Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 03/30/2026, revealed the facility assessed R43 to have a Brief Interview for Mental Status (BIMS) of nine out of 15, which indicated moderate cognitive impairment. Review of the facility's final investigation dated 07/26/2026, revealed on 07/25/2026, Registered Nurse (RN) 1 checked to ensure R43 had his narcotic pain medication available if he should need it for breakthrough pain, and found there were not any available. Per review, RN 1 phoned the pharmacy to check for an order to refill R43's narcotic medication. Continued review revealed the pharmacy notified RN 1 that R43's medication had been filled and delivered to the facility on [DATE] (two days previously) with the 6:30 AM delivery that day. According to the investigation review, the facility performed interviews and drug screens of all nursing staff who had access to the medication cart from 07/23/2026 at 6:30AM to 07/25/2026 at 5:00 PM, when the medication was discovered missing. Further review of the investigation revealed one of the nurses interviewed, RN 2, had suspicious behavior such as, at times discouraging other staff from counting the narcotics on the medication carts. Per review, RN 2 also had accidentally taken home a resident's medication on 07/23/2026; however, returned the medication the same evening at 11:30 PM. In addition, review revealed RN 2 failed to sign R43's narcotic pain medication (Norco 7.5 mg) into the medication cart as requested by KMA 1 and the missing narcotic medication was never located. Review further revealed the facility suspended RN 2, with termination pending. During an interview, on 07/31/2026 at 8:54 AM, Pharmacy Consultant 1 stated R43's Norco (narcotic pain medication used to treat moderate to severe pain) 7.5 milligrams (mg) 30 count blister pack had been delivered to the facility on [DATE]. During an interview, on 07/31/2026 at 12:50 PM, Licensed Practical Nurse (LPN) 2 stated she had received the narcotic pain medication for R43 in the pharmacy delivery on 07/23/2026. She stated she asked Kentucky Medication Aide (KMA) 1 to assist her with logging in the narcotic medication. During an interview, on 07/31/2026 at 11:12AM, KMA 1 stated she had been asked by LPN 2 to put the narcotic medication in the medication cart and sign them in. She stated she placed the narcotic medication in the cart as (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	requested. KMA 1 stated a blue sheet came with the narcotic medication from the pharmacy which the receiving facility staff person and pharmacy staff person signed and each got a copy of it. KMA 1 stated the procedure for signing in narcotics medications included the white sheet (used for tracking the narcotic count on the medication cart), which was the log for the number of blister packs of the narcotic medication. The KMA stated when a new narcotic medication was received from pharmacy, facility staff added the new blister pack to the total of the medication on the back side of the white sheet. She stated (on 07/23/2026) she told the oncoming nurse, RN 2 she (the RN) would need to fill out a blue sheet and a white sheet for R43's Norco 7.5 mg medication. She stated however, she should have done that herself. During an interview, on 07/31/2026 at 2:00 PM, RN 1 stated, on 07/25/2026, R43 requested as needed (PRN) pain medication. RN 1 stated she went to pull the PRN pain medication; however, the medication was unavailable. She stated she contacted the pharmacy to ensure R43 had a prescription on file. RN 1 stated the pharmacy told her 30 pills had been sent and received by LPN 2 on 07/23/2026 at 6:30 AM. During an interview on 07/31/2026 at 9:06 AM, the Director of Nursing (DON) stated the facility did not have a policy for checking in narcotic medications or a drug diversion policy. The DON stated the Unit Managers (UM) audited a couple of times per week on the narcotic medications. The DON further stated, however, the UM for Blue Unit failed to follow the auditing process and had been suspended. During an interview, on 07/31/2026 at 8:54 AM, Pharmacy Consultant 1 stated R43's Norco (narcotic pain medication used to treat moderate to severe pain) 7.5 milligrams (mg) 30 count blister pack had been delivered to the facility on [DATE].		