STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185240	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middlesboro Nursing and Rehabilitation Facility	235 New Wilson Lane Middlesboro, KY 40965

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, record review and facility policy review, the facility failed to administer medications in accordance with provider order and established nursing practice for 1 of 19 sampled residents, Resident 3 (R3).Review of facility investigation, and interviews with Licensed Practical Nurse (LPN) 2, revealed R3 received medications per rectum rather than the ordered oral route.The findings include:Review of facility policy, Medication Administration Policy, subtitled Medication Preparation, last reviewed 12/22/2025, revealed the facility would ensure medications were administered as prescribed in accordance with manufacturers' specifications, as well as good nursing principles and practices. Further review revealed medication tablets may be crushed or capsules emptied out when it is safe to do so and when a resident has difficulty swallowing or is tube-fed and with a specific order from the prescriber. Continued review revealed the need for crushing medications must have been indicated on the resident's orders and the MAR medications were administered in accordance with written orders of the prescriber.Review of facility policy, Medication Administration Policy, subtitled Medication Administration, last reviewed 8/04/2024, revealed medications were administered in accordance with written orders of the prescriber. Further review revealed if a dose of scheduled medication was refused, a rationale should be given.Review of facility policy, Medication Discrepancy Report, dated 08/16/2011, revealed medication errors and drug reactions must be reported immediately to the Director of Nursing (DON), the resident's attending physician and the resident's responsible party, following a thorough assessment. Further review revealed a medication error was forwarded to the QAPI committee for analysis and would become part of the QAPI Committee minutes.Review of R3's admission Record revealed the facility admitted the resident from an acute care facility on 12/19/2022 with diagnoses including Unspecified cerebrovascular disease, Paranoid schizophrenia, and bipolar disorder. Review of R3's initial Minimum Data Set (MDS) assessment revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of 12 out of 15 which indicated he was cognitively intact. Further review of R3's medical record revealed he was discharged to inpatient psychiatric service on 05/21/2024. Continued review revealed R3 was his own responsible party.Review of R3's orders revealed, as of 04/16/2023, his diet was Controlled Carbohydrate (CCHO) with regular texture and thin liquids. Further review revealed R3 took medications whole.Review of R3's April 2023 Medication Administration Record revealed, on 4/16/2023 there were 14 medications scheduled at 8:00 PM and 9:00 PM, that LPN3 had administered. Those medications were:Atorvastatin Calcium, 20 milligrams (mg) by mouth (po) at bedtime (hs)Finasteride 5 mg po hsTrazodone Hydrochloride 75 mg po hsAmitiza 8 mcg po twice daily (bid)Benztropine Mesylate 0.5 mg po bidCelecoxib 100 mg po hsHaloperidol 2 mg po bidMetoprolol 25 mg, 1/2 tablet, po bidMucinex 60 mg po bidBaclofen 10 mg po three times a day (tid)Depakote Sprinkles 125 mg po tidGabapentin 100 mg po tidPolyethylene Glycol powder 17 gram po tidSucralfate 1 gram po before meals and hsReview of R3's progress notes revealed there was no documented evidence the route of medication administration had changed on 04/16/2023.Review of facility's General Investigation (Quality Assurance/Confidential), signed by the DON and the Administrator on 4/17/2023, revealed R3 stated to the resident had requested medication be administered rectally and the nurse followed his request. The incident was documented (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185240	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middlesboro Nursing and Rehabilitation Facility	235 New Wilson Lane Middlesboro, KY 40965

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as a medication error. Further review revealed nursing assessment revealed R3 was alert and oriented and had sustained no injury. Continued review revealed he had made no complaints and was educated during the interview regarding medication administration. Additional review revealed the nurses received a verbal reprimand and re-education, including the 5 Rights of Medication Administration, and the different routes of medication administration. R3 was his own responsible party but his daughter was notified, as well as the physician, and he was educated about the correct route of medication administration. Review of the risk and causal factors to the incident revealed R3 requested medications be administered rectally rather than by mouth and the nurse followed his request. The nurses were educated via phone after they had departed from the shift for verbal reprimand and education provided along with follow up education regarding Five Rights of Medication Administration and that she should have contacted the nurse practitioner or physician to request further instruction. Continued review revealed R3 received assessment on the following two days with no changes noted. Additional review revealed nurse interviews were that R3 refused to take his medication by mouth but would take them rectally, and they had complied with his request by crushing meds and administration per rectum. They reported he had exhibited no change in condition for the rest of the shift. Review of the Nurse Practitioner progress note, dated 04/18/2023, revealed the visit was at the request of the facility and was unremarkable for change of condition or any new complaints. Review of Employee Conference with LPN 3, dated 04/17/2023, revealed she received verbal reprimand regarding administering medication per rectum. She received education that the physician had to give an order to change the route of administration. She was further educated to call the DON or Assistant Director of Nursing (ADON) for direction when she was in a situation that she did not know what to do. Continued review revealed LPN 3 voiced understanding and verbalized she would administer medications per the ordered route. Additional review revealed LPN 2 received the same reprimand and education though while she voiced understanding, she stated she thought she was not doing anything wrong. Review of QAPI Summary, dated 04/20/2023, revealed the agenda item of Review of the 5 Rights of Medication Administration. Review of Medication Report, dated 01/09/2023, revealed LPN 3 had been successfully checked off for medication administration approximately three months prior to the incident.Review of the in-service record, revealed all licensed nursing staff were educated on the topic of Medication Administration from 04/17/2023 - 04/21/2023 in face-to-face format. Further review revealed specific focus on route of administration with follow up on medication passes by the Quality Assurance nurse, the ADON and DON. Further review revealed education covered the five rights of medication administration with key takeways that correct medication administration requires close attention to detail, that the five rights are the right patient, right drug, right time, right dose and right route and that understanding medication routes of administration helps improve medication safety. Continued review revealed 20 medication administration reminders, including the 5 Rights of Medication Administration.LPN 3 was not available for interview, as she is no longer employed at the facility, moved out of state and no contact information was known for her.During interview with LPN 2 on 06/10/2026 at 9:40 PM, she stated R3 did receive medications rectally on one occasion. She stated LPN 3 was a new graduate and had reported R3 refused to take his medication orally but had stated he would only take them if given rectally. She stated LPN3 crushed the medication as directed when administering with applesauce but placed in lubricant and administered rectally as the resident had requested. She stated he did not scream out in pain or report feeling as though he had been raped. She further stated that she did not remember the date when this occurred, but it was quite a while before he was discharged . LPN2 stated she rounded on him later and he was in no distress and was pleasant with no report of feeling violated. She stated it was consistently apparent when he refused his psychiatric medications as evidenced by changing moods and behavior and that he felt better when he did have them. She stated the appropriate strategy if he refused medications and requested a different route would be to call the provider to notify and ask if he/she had different orders. During interview with LPN 4 on 06/12/2026 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185240	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middlesboro Nursing and Rehabilitation Facility	235 New Wilson Lane Middlesboro, KY 40965

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 9:45 AM, she stated it was necessary to call the provider for an order to change a medication, including the route. During interview with LPN 5 on 06/12/2026 at 9:55 AM, he stated if a resident refused medication and wanted it via different route, first should educate them then would call the provider to report. At that point, he would be up to their judgement. In further interview, he stated the bottom line was a nurse has to give medications how they are ordered.During interview with LPN 6 on 06/12/2026 at 10:05 AM, she stated if a resident refused oral medications and wanted a different route, she could not do that without a provider order, so would have to call and report the refusal. During interview with RN 2, a member of QAPI, on 06/12/2026 at 1:47 PM, she stated they took the medication error issue to QAPI, and part of that process was all the nurses had medication pass education with the five rights, what to do if there is a question (notify provider), then audits consisting of observation of medication pass with various nurses. She stated she did not recall how long the audits went on but did remember they were being done to ensure that all the nurses were carrying out the education as provided. She stated any nurse should call the doctor to notify of an issue with medication and obtain guidance for what he or she wants the nurse to do.During interview with LPN 8, who was a member of QAPI, on 06/12/2026 at 1:56 PM, she stated, QAPI met on 04/20/2023 after this incident happened on 04/16/2023. She stated there was education afterwards with the nursing staff about medication administration. She stated it was addressed immediately, making sure staff were aware of what had happened, what to do in that situation if it were to come up again. She stated there were observations/spot check/audits of medication pass after this and on a routine basis where they watch for residents to be receiving their medication in a timely manner and correctly.During interview with ADON on 06/11/2026 at 10:07 AM, she stated the incident with R3 was three years ago. She stated she did not recall why the staff came to tell her about the rectal administration. She stated she had talked to R3 that morning after she had been notified and he was fine, did not report feeling violated, did not mention feeling like he was raped. She stated the two nurses were working together, and that one was a new graduate. She stated she did not recall who specifically gave the medicine, but after reviewing the original investigation, she felt like it was the new grad, who is no longer employed at the facility. In further interview, she stated the implication was that the resident stated he would not take his meds orally but he, himself, stated he would take them rectally. She stated she did not recall the discussion of what led to that decision on the part of the nurse or how it came to light that leadership was made aware. She stated they were educated they must follow the order as written and if resident requested otherwise, the provider had to give an order to change the route of administration. In continued interview, she stated their actions following this incident, investigation and education, was following it with audits/spot checks to ensure compliance.During interview with Nurse Practitioner (NP) on 06/11/2026 at 4:06 PM, she stated she did not recall R3 having swallowing difficulties at that time. She stated she did not remember being called about R3 refusing medications or for a different order. In further interview, she stated receiving the medications per rectum would not have hurt him physically and the medications would still work. During interview with the Medical Director (MD) on 06/12/2026 at 10:26 AM, he stated if an order was written for a medication to be administered by mouth, the nurse should contact the physician for clarification and direction if the resident preferred another route. He stated safety with giving medication rectally would depend on the medication, but generally oral medications were safe for rectal administration and was doubtful of harm potential. During interview with the DON on 06/12/2026 at 11:49 AM, she stated she was part of the QA/QAPI process and was in attendance at the meeting following the incident. She stated she found out about R3's incident because the following morning he had told the nurse he got meds in his butt, so the nurse alerted her. She stated she went to see him and educated him that the nurses could not give meds except the way they were ordered, that they would have to call the doctor that to be ordered. She stated he huffed about that. She stated she called the nurses right away and they received a verbal reprimand and documented it on QA conference form. She stated she provided Medication administration re-education to all the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185240	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Middlesboro Nursing and Rehabilitation Facility	235 New Wilson Lane Middlesboro, KY 40965

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurses over the next few days and also placed laminated references in the narcotics book so they were always available on the cart. This included 5 Rights, what to do if out of a medication, what to do if there is any question. In further interview, she stated they followed this with audits/spot checks of medication administration to ensure compliance. In additional interview, she stated he had no change of condition in response to the incident. He transferred to inpatient psych later on, like a year later, so not related. During interview with Administrator on 06/12/2026 at 3:33 PM, she stated her expectation for a situation like that with medication administration, was to give in accordance with the MAR, or call the doctor to ask for guidance or further instructions. She stated the first leadership response was assessing and interviewing the resident. In further interview, she stated they initiated education with the nurses to ensure they all understood the five rights and reaching out to the physician for order changes. She also stated they have not had an issue since, that it was a single incident. In continued interview, she stated they conducted spot checks/audits with medication administration and interviewed residents who could engage about the circumstances. She stated they asked them if there were any issues with the medications, and how they were given. Then, she stated they took the issue to Quality Assurance/QAPI, just 3 days later after education was started, assessments and audits.