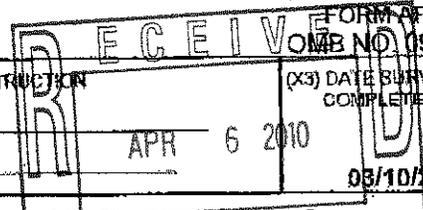


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2010

FORM APPROVED  
OMB NO 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185280	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/10/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LETCHER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 73 PIEDMONT DRIVE Whitesburg, KY 41858 Division of Health Care Southern Enforcement Branch
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS	F 000		
F 250 SS=D	<p>A standard health survey was conducted on March 8-10, 2010. Deficient practice was identified with the highest scope and severity being at an "E" level.</p> <p>An abbreviated standard survey (KY14326) was conducted on March 8-10, 2010. No deficient practice was identified related to the allegation.</p> <p><b>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</b></p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide medically related social services for two (2) of twenty-six (26) sampled residents. There was no evidence the facility had provided dental services for residents #16 and #20.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>A review of resident #16's medical record revealed a 57-year-old resident with a diagnosis of Peripheral Vascular Disease resulting in bilateral amputations above the thigh level. Resident #16 was assessed on an admission assessment dated October 17, 2009, and a quarterly assessment dated January 14, 2010, as being independent with decision-making.</li> </ol> <p>A review of resident #16's dental care plan</p>	F 250	<p>Letcher Manor does not believe nor does the facility admit that any deficiencies exist. Letcher Manor reserves all rights to contest the survey findings through informal dispute resolution, appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard of care, contract, obligation or position. Letcher Manor reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Letcher Manor does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. Letcher Manor offers its responses, credible allegations of compliance and plan of correction as part of its on-going effort to provide quality care to residents. Letcher Manor strives to provide the highest quality of care while ensuring the rights and safety of all residents.</p> <p><b>F250 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</b></p> <p>Letcher Manor strives to provide the highest quality of care to all residents, which includes individual resident assessments and provision for medically related social service needs for each resident.</p> <p>It is the policy of this facility to provide dental care through the services of a consultant</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carla E. Bishnor, Administrator TITLE: \_\_\_\_\_ DATE: 4/2/10

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2010  
FORM APPROVED  
OMB NO. 0938-0391

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  03/10/2010
NAME OF PROVIDER OR SUPPLIER  LETCHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 73 PIEDMONT DRIVE WHITESBURG, KY 41858		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 250	<p>Continued From page 1</p> <p>revealed resident #16 had his/her own teeth with several missing/broken/loose and carious teeth.</p> <p>The resident's dentist visited the facility on December 23, 2009, and an examination of resident #16 revealed different areas of dental decay. The dental decay was located in one of the resident's top teeth. The five other areas of dental decay were located in the resident's bottom teeth. According to the dental exam, the treatment plan stated, "No pathologies at this time."</p> <p>An interview with resident #16 on March 10, 2010, at 1:50 p.m., revealed the dentist evaluated resident #16's teeth at the facility and the resident had six teeth with cavities. Resident #16 further stated some of his/her bottom teeth were broken, and were loose, which made it hard for the resident to eat. The resident stated it hurt to eat hard foods and the resident was only able to chew soft foods. Resident #16 further stated he/she was awaiting a follow-up appointment and was unsure if insurance would pay for the dental work.</p> <p>An interview with the Social Services Director (SSD) on March 10, 2010, at 2:00 p.m., revealed the resident had received a dental examination on December 23, 2009; however, the social worker had not followed up with resident #16 to discuss any further appointments to the dentist for any needed repairs. The SSD stated the resident had not discussed any difficulty the resident was having with chewing. The SSD stated that it was within the SSD's job description to make appointments for the residents as needed, and to make arrangements for transportation for the resident attend appointments. The SSD further</p>	F 250	<p>dentist. This facility does not provide on-premise dental services. The consultant dentist is retained, visits the facility residents at minimal, annually, and is responsible for: providing consultation to physicians, providing a dental assessment of each resident as needed, performing dental re-evaluation for each resident as needed, providing in-service education, ensuring emergency dental services are available, and providing necessary information on residents to appropriate staff and care planning conferences.</p> <p>It is the policy of Letcher Manor to prepare and review resident assessments and to develop the comprehensive care plan for each resident through a qualified Interdisciplinary Care Planning Committee or Team. The Care Planning Team includes, but is not limited to: SSD, Registered Nurses, Director of Nursing (as appropriate); Dietary Manager, Dietician, Therapist, Charge nurse responsible for resident care, as well as Physician approval; and others as appropriate or necessary, such as the Dental Consultant.</p> <p>This is evidenced by the following actions:</p> <p>Resident # 16 medical records do NOT reflect the resident informed the Charge Nurses or the Social Service Director (SSD) of any mouth or dental discomfort or need for dental services. Resident #16 was observed and interviewed DAILY by nursing staff to determine any pain or discomfort issues, and this was documented per the Medication Administration Record. In addition, formal nursing assessments for pain issues were performed weekly and quarterly which did not reflect any notification or observation of mouth pain. Oral Assessments were performed on October 5, 2009, October</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2010  
FORM APPROVED  
OMB NO. 0938-0391

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  03/10/2010
NAME OF PROVIDER OR SUPPLIER  LETCHER MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 73 PIEDMONT DRIVE WHITESBURG, KY 41358		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	<p>Continued From page 2</p> <p>stated the SSD was to make arrangements for residents regarding the method of payment for services provided to the residents related to any appointments/referrals. The SSD did not talk with the resident about any follow-up appointments regarding resident #16's teeth until made aware by the surveyor on March 10, 2010, at which time a follow-up appointment was made.</p> <p>An interview with the Office Manager (OM) at the dentist office on March 10, 2010, at 2:45 p.m., revealed that the dentist visits the facility one time per year and evaluates those residents that the facility decided would be difficult to see at the dental office. The OM stated the facility made any follow-up appointments that were needed. The OM stated that the SSD had contacted the dentist on March 10, 2010, to make a follow-up appointment for resident #16 for future dental work to be performed.</p> <p>2. A review of the medical record revealed resident #20 was admitted to the facility on March 24, 2009, with diagnoses of Hypertension, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus, and Seizure Disorder. The diagnoses list was updated on February 6, 2010, to include a diagnosis of Cerebral Vascular Accident (CVA).</p> <p>A review of the admission comprehensive assessment dated April 5, 2009, revealed resident #20 was assessed to have no problems with short and long-term memory recall and to be independent with decision-making skills. The assessment further identified the resident to have "some/all" natural teeth missing. A review of the Resident Assessment Protocols (RAPs) dated April 5, 2009, revealed resident #20 was</p>	F 250	<p>15, 2009 and on January 14, 2010. According to the nursing Oral Assessment, the resident denied any problems with current dental status. The SSD and the Dietary Director interviewed this resident during the same time frames as noted above, and this resident did not indicate pain with the mouth or eating issues at those times or made staff aware of any mouth discomfort. The social service note made on January 14, 2010 indicated "no social service needs."</p> <p>The Dental Consultant is scheduled to do routine examinations on EVERY resident annually. The Consultant made an annual on-site visit on December 23, 2009 in which all residents were examined that provided permission for services. Resident #16 was examined; however, the consultant did not note that a follow up visit was necessary at that time. He noted, "no pathologies at this time." The SSD followed up with the dental office for all necessary appointments, however it was not deemed necessary at that time to pursue treatment for Resident #16. Per the Surveyor records as noted, even the Office Manager of the Dental Office told the Surveyor that the "facility made any follow up appointments that were needed."</p> <p>Nursing staff aggressively attempted to identify the resident's needs, by follow up on any pain issues on a DAILY basis via interview with resident. Again, the resident had not made complaints regarding mouth pain or discomfort. Staff was as aggressive as possible in attempting to obtain information, to identify a need, as reasonably as possible, and was limited only by the extent the resident would not inform the staff.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2010  
FORM APPROVED  
OMB NO. 0938-0391

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  03/10/2010
NAME OF PROVIDER OR SUPPLIER  LETCHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 73 PIEDMONT DRIVE WHITESBURG, KY 41853		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 250	<p>Continued From page 3</p> <p>edentulous and did not wear dentures. The RAPs further noted dental care would be provided every shift and as needed, and dental appointments would be scheduled as needed.</p> <p>A review of the dental consultation conducted on December 23, 2009, revealed resident #20 was edentulous and no pathologies were identified during the exam.</p> <p>An interview conducted with resident #20 on March 10, 2010, at 1:30 p.m., revealed the resident had a full set of dentures at the dentist's office. The resident was unable to recall when the resident had seen the dentist or the name of the dentist. Resident #20 stated the Social Services Director (SSD) knew about the dentures. The resident stated the SSD had informed the resident that there was no money available to obtain the dentures. Resident #20 stated the resident had been edentulous for four years, but had no problems chewing.</p> <p>An interview conducted with the SSD on March 10, 2010, at 1:50 p.m., revealed resident #20 did not have funds to pay for the dentures. The SSD stated resident #20 had talked with the SSD about obtaining dentures, but the SSD was unaware that dentures had been made for resident #20. The SSD stated he told resident #20 that the SSD would see if there were some alternative measures to obtain payment for the dentures. The SSD stated this discussion occurred sometime in mid-2009. The SSD stated the SSD had contacted different organizations to obtain financial assistance with payment for the resident's dentures after talking with resident #20, but had not followed up on the situation. The SSD further stated no dental evaluations had</p>	F 250	<p>Resident #16 comments to the surveyor, that they were only able to chew soft foods, is not substantiated by the evidence of other medical records. Resident #16 has been shown to eat 100% of meals, is on a REGULAR DIET, and has not experienced any weight loss, but has gained fourteen (14) pounds since December, 2009. There were no symptoms or signs recorded in the medical chart anywhere, to indicate an immediate medical/dental need, or by daily interviews with the resident.</p> <p>Resident #16 did, however, make staff aware, as evidenced by the medical record, that he experienced pain in the leg and back areas, which was promptly addressed and effectively managed. Resident is independent for eating meals and also independent for mouth care. As noted by the surveyor, this resident is independent with decision making, and was more than capable of notifying staff should there have been an issue of discomfort or pain in the mouth area.</p> <p>Resident #20 has an incorrect date noted on the deficiency statement. The dates as noted to be "mid-2009" were actually "mid-2008," which were in a previous survey period. The medical records of 2008 reflect the resident was admitted for a short term stay in January 2008. Resident informed the Social Service Director (SSD) on April 9, 2008, that resident had been "fitted" for dentures. The SSD started the process of finding alternate sources for payments, and made a follow up note of this on April 11, 2008. Upon notifying the family, they informed the SSD that there were never any dentures and had not been in over four (4) years. The resident discharged home on May 5, 2008 prior to attending any further dental appointments. This occurred during a previous</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2010  
FORM APPROVED  
OMB NO. 0938-0391

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  03/10/2010
NAME OF PROVIDER OR SUPPLIER  LETCHER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 73 PIEDMONT DRIVE WHITESBURG, KY 41858	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 250	Continued From page 4 been obtained for the resident since the resident was admitted to the facility until the dentist made a routine visit in December 2009.  A review of the SSD notes dated April 16, 2009 through February 25, 2010, revealed no evidence the SSD had made any attempts to provide medically related social services for resident #20 related to dental care.	F 250	admission, and reflected timely follow up for this resident at that time. In January 2009, this resident was readmitted and did not indicate a need or wish to further pursue dentures to any staff member. Resident was able to maintain eating a REGULAR diet without issue. Dental care language as noted in the RAPs, are used in conjunction with and indicative of general mouth care, which would include cleansing of oral areas, including gums, tongue, etc. Oral Assessments provided quarterly by nursing staff have not indicated the need for referral to a Dental Consultant; therefore a social service referral would not have been made. The social note, made after interviewing with this resident, indicated further review and conclusion by recording "no social service needs" on July 1, 2009, September 17, 2009, December 2, 2009 and February 25, 2010. The Dental Consultant evaluated this resident with permission on December 23, 2009, and found no further treatment needed.	F250 4-2-10
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide services to meet professional standards of quality for two (2) of twenty-six (26) sampled residents (residents #26 and #6). Observation during medication pass on March 8, 2010, revealed staff failed to administer eye drops per accepted professional standards. In addition, resident #6 had a dietary recommendation that was not implemented.  The findings include:  1. Observation during medication pass on March 8, 2010, at 4:30 p.m., revealed LPN #1 administered Brimonidine Tartrate 0.15% (Alphagan) eye drops to resident #26. The LPN instilled one drop of Alphagan to resident #26's left eye and then proceeded to administer the eye drops to the right eye without washing hands or changing gloves. The LPN also wiped resident	F 281	1. Resident #16 was interviewed by staff on March 10, 2010 and resident now indicates he would like for an appointment to be made for further follow up of dental services. Social Service Director contacted Dental Consultant for an appointment on March 10, 2010. An appointment has been scheduled for this resident. Resident #20 and their family were interviewed and neither desires for dentures to be pursued at this time. Speech Therapy evaluation note of March 19, 2010, indicates to change resident to mechanical soft diet due to the medical condition of weakness. The Speech	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2010  
FORM APPROVED  
OMB NO. 0938-0391

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  03/10/2010
NAME OF PROVIDER OR SUPPLIER  LETCHER MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE 73 PIEDMONT DRIVE WHITESBURG, KY 41858	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
F 281	<p>Continued From page 5</p> <p>#26's left eye with a tissue and then used the same tissue to wipe the right eye.</p> <p>Interview on March 9, 2010, at 1:15 p.m., with LPN #1, revealed the LPN was not aware of the need to wash hands and change gloves before administering the eye drops to the second eye. LPN #1 stated the LPN probably would wash/change gloves if the resident had an antibiotic eye drop ordered to prevent the transferring of germs from one eye to the other.</p> <p>Interview on March 9, 2010, at 2:50 p.m., with the Quality Assurance/Infection Control Nurse/LPN #2 revealed it was LPN #2's opinion that staff should wash hands/change gloves before administering an eye drop to a resident's second eye.</p> <p>The facility provided a policy/procedure related to the administration of eye drops on March 10, 2010, at 10:30 a.m., which revealed staff should wash hands if administering eye drops to a resident's second eye.</p> <p>The facility supplied a second policy on March 10, 2010, at 2:25 p.m., entitled Eye Drop Administration. The second policy revealed the policy had been updated in October 2007. No date was found on the first policy. The second policy only directed staff on the proper procedure of administering eye drops to one eye.</p> <p>2. A review of the medical record for resident #6 on March 8, 2010, revealed resident #6 was assessed to require continuous tube feedings of Fibersource HN related to poor intake. The physician's orders for February 2010 revealed the tube feeding was to infuse via an enteral feeding</p>	F 281	<p>Therapist stated this evaluation would not support the need for dentures at this time.</p> <p>2. The facility reviewed all resident records to ensure that any/all residents in need of dental services were identified for the service. No residents were identified to have an unmet need. Should the need arise for dental services the facility policy shall be implemented.</p> <p>3. An educational in-service regarding dental policy and procedure was provided on March 25, 2010 with the SSD; and also on April 2, 2010 with all nursing staff regarding facility policy on dental services. All new nursing staff shall be oriented to the policy upon hire; and the policy shall be reviewed with staff if or when a problem is identified. The SSD shall interview residents, face-to-face, upon each scheduled assessment, and as needed regarding any specific dental needs or issues. In addition, the DSS, or the designee, shall be notified immediately upon any resident request, complaint or assessment for dental service needs to ensure dental services are received, and proper assessment and review is performed by the Interdisciplinary Team.</p> <p>4. To ensure solutions are sustained in regards to the above, the Director of Nursing shall implement Quality Assurance measures to review quarterly, the adherence to facility policy for provision of dental services. The review will include interview of administrative and nursing staff, and shall include face-to-face interviews of 5% of facility residents and review of their medical records. Evaluation reports will be distributed to the</p>

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2010  
FORM APPROVED  
OMB NO. 0938-0391

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  03/10/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LETCHER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 73 PIEDMONT DRIVE WHITESBURG, KY 41858
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 281	<p>Continued From page 6</p> <p>pump at a rate of 40 cc per hour. The physician's orders further revealed that resident #6 was ordered a regular mechanical soft diet with thin liquids. A review of the dietitian's progress notes revealed that on February 18, 2010, a dietary recommendation was written in the chart for the Fibersource HN to be increased to 45 cc per hour via enteral feeding pump.</p> <p>Observations of resident #6 on March 8, 2010, at 3:45 p.m., 5:30 p.m., and 5:57 p.m., on March 9, 2010, at 9:05 a.m., 10:45 a.m., and 12:05 p.m., and on March 10, 2010, at 10:00 a.m., revealed the tube feeding pump to be infusing Fibersource HN at 40 cc per hour via the enteral feeding pump.</p> <p>An interview with the registered dietitian on March 9, 2010, at 11:00 a.m., revealed the dietitian had recommended that the tube feeding be increased on February 18, 2010.</p> <p>An interview with the Unit Coordinator on March 10, 2010, revealed when a dietary recommendation was written, the dietitian writes the recommendation on a dietary recommendation sheet for the nurses to contact the physician regarding the recommendation, and obtain orders if needed for the resident. The Unit Coordinator reported that according to the February 18, 2010 dietary recommendation sheet there were no recommendations for resident #6.</p> <p>A review of the dietary recommendation sheet for February 18, 2010, revealed no recommendations were made for resident #6.</p> <p>A follow-up interview with the dietitian on March 10, 2010, at 1:50 p.m., revealed that the dietitian</p>	F 281	<p>Administrator for review and appropriate action taken as necessary.</p> <p>5. F 250 April 2, 2010</p> <p><u>F281 483.20(k)(3)(1) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</u></p> <p>Letcher Manor strives to provide services that are being met with professional standards of quality and care that are provided by appropriate qualified persons; which would include licensed nurses for medication administration and Consultant Dietitians for proper resident assessments and recommendations.</p> <p>This is evidenced by the following actions:</p> <p>Resident # 26 medical records reflect the Resident's Charge Nurse (LPN) did administer Brimonidine Tartrate 0.15% eye drops on March 8, 2010 at 4:30 p.m. Medical records for this resident also reflect there was NO active eye infectious process with this resident. This medication was being provided for an abnormal condition of Glaucoma, related to elevated pressure in the eye.</p> <p>The Charge Nurse did not wash her hands between eyes; however, she did use a different finger to apply pressure to the other eye's tear duct. This followed current facility policy and procedure and is within acceptable standards of practice.</p> <p>The facility policy was updated to the professional standards of the American Society of Consultant Pharmacists (ASCP) in October 2007. The Surveyor was mistakenly provided the policy from the older manual, but this was promptly corrected, and the Surveyor was provided the correct policy that was in use at the time of the survey, which was dated October</p>	
-------	---	-------	---	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2010  
FORM APPROVED  
OMB NO. 0938-0391

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  03/10/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LETCHER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 7a PIEDMONT DRIVE WHITESBURG, KY 41858
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	OSI COMPLETION DATE
--------------------	--	---------------	---	---------------------

F 281	Continued From page 7 failed to write the recommendation on the dietary recommendation sheet. The dietitian stated that a recommendation would be made for resident #6 to have the tube feeding increased to 45 cc per hour via enteral feeding pump.	F 281	2007. The Surveyor was also provided <i>written verification</i> of the current and correct policy in use by the facility and verified by the Consultant Pharmacist. This very policy was revised by the Consultant Pharmacy Group on October, 2007 and according to professional standards of ASCP and distributed to this facility at that time.	F281 4-2-10
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Two resident rooms had bedside tables with rough, chipped edges. A nightlight plate cover was loose in one (1) resident room. Seven (7) resident rooms had exposed commode screws extended upward. A light bulb was out in one (1) resident room. There was scraped drywall/wallpaper in two (2) resident rooms. Bathroom door handles were loose in two (2) resident rooms. One (1) room had a stain in the commode basin. The entry doors to two (2) resident rooms were scraped and splintered.  The findings include:  Observation during the environmental tour on March 8-9, 2010, revealed the following were in need of repair:  -A bedside rolling table was observed to have	F 465	According to written statements obtained on March 8, 2010 from the LPN, and the LPN Supervisor who was also observing the medication pass, the following was performed: <ul style="list-style-type: none"> <li>the LPN washed her hands prior to the procedure and applied gloves</li> <li>the LPN informed Resident of procedure and requested proper head position</li> <li>the LPN used the right little finger to position the right lower conjunctival sac and applied medication per policy</li> <li>the LPN moved to the left eye, used the left little finger to position the left lower conjunctival sac and applied medication per policy</li> <li>the LPN asked the resident if they needed a tissue. The resident took the tissue and the resident wiped the face area and gave the tissue back to the LPN to discard</li> <li>the LPN folded the tissue into the glove and removed the gloves and washed her hands.</li> </ul> <p>The ASCP standard of practice, which this facility utilizes, (Form #A001) is below: <b><i>If a dose is required in the other eye, repeat procedures. To lessen the chance of cross-contamination, use a different finger to apply pressure to the other tear duct, OR wash hands between eyes. This is particularly important</i></b></p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/24/2010  
FORM APPROVED  
OMB NO. 0938-0391

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  03/10/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER  LETCHER MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 73 PIEDMONT DRIVE WHITESBURG, KY 41858
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 485 Continued From page 8

rough, chipped edges in resident rooms 152 and 164.

- The nightlight plate cover was loose from the wall in room 164.
- An exposed screw was observed to extend upward approximately two inches from the commode base in resident bathrooms 102, 112, 115, 128, 141, 145, and 152.
- A bulb was out in the light of resident bathroom 145.
- Scraped drywall/wallpaper was observed in resident rooms 120 and 140.
- The bathroom door in resident room 132 exhibited a squeak when opened.
- The bathroom door handles in resident rooms 132 and 152 were loose.
- A stain was observed in the commode basin in room 132, and
- The entry doors to resident rooms 106 and 115 were observed to have been scraped, which exposed splintered wood.

Interview on March 10, 2010, at 3:10 p.m., with the Director of Maintenance revealed daily rounds were made to observe for items that needed repair. The Director of Maintenance stated the items identified by the surveyor had not been reported or identified by staff.

F 485 when an active eye infection is being treated.

Although there was no infectious process, the nurse continued to utilize a HIGHER standard of practice with this resident than was required.

This facility and the pharmacy, which this facility utilizes, have been unable to find ANY standard of practice that says hand washing MUST be done between administering medication of both eyes. The manufacturer guidelines for these eye drops did not provide specifics as to the proper administration. All Nursing staff had been in-serviced on February 5, 2010 regarding the October, 2007 policy and procedure related to "administration of eye drop medication". There was no potential for a negative outcome related to this LPN's administration of eye drop medication, and especially since there was no eye infection.

Resident # 6 medical records revealed that this facility was following the current Physician's Order of 40cc tube feeding, by the Medication Administration Record, by direct observation, Dietician note and supplemental dietary recommendation records at the time of survey. The Dietician's note on February 18, 2010 stated "recommend increase Fibersours HN to 45 cc/hr x 20 to help stabilize weight," however, the Dietician wrote at the end of that same note "will monitor no recommendations at this time." The Dietician provided the Director of Nursing, Administrator and nursing staff with a supplemental sheet for follow up with the physician, which also stated, "no recommendations at this time."

In addition, prior to the Consultant Dietician leaving the building, an exit interview to discuss recommendations and/or issues are made

F465  
4-2-10

**(CONTINUED FROM PG 9 OF 15)**

verbally with the Director of Nursing, or the designee, to ensure appropriate communication for the care of the resident. ***The Dietician verbally confirmed "No Recommendation" for this resident.***

The Speech Therapist evaluated the resident on February 19, 2010 for a bedside swallow assessment with reports of decreased appetite, and recommended another calorie count and to adjust tube nutrition through the PEG ***if resulted in decreased calorie count with p.o. intake. However, the calories increased.*** According to the Speech Therapist recommendation, an adjustment in tube feeding was not necessary at that time.

The January calorie count indicated 72.6% of calories from tube feeding, and 27.4% calories from oral intake. The February calorie count indicated 67.9% for tube feeding, and increased oral intake to 32.10%.

This resident's weight was 106.2 at the time of the Dietician's note of February 18, 2010. The resident's admit weight was 102.6, and the resident's ideal body weight range was 90 to 110 lbs., as calculated by the Consultant Dietician.

The Physician's written statement on March 10, 2010 in regards to this matter, noted, "this patient has experienced no negative outcome from the dietary recommendation written on 2/18/10..."

Although the Consultant Dietician may have informed the Surveyor that she **made an error in the note and supplemental form**, and "meant" to have the tube feeding increased to 45cc as a preventative measure to stabilize weight changes; this was not the final recommendation according to the medical

**(CONTINUED FROM PG 10 OF 15)**

record or the Dietician's exit interview with staff. It would not be an appropriate standard of practice for this facility to follow what a Consultant "meant to do," but didn't. This is not reasonable to expect.

Therefore, all documentation in the current medical record had been followed by this facility per the current orders, status and review of this resident.

1. Resident # 26 had no potential or negative outcome from the procedure used for administration of eye drops per the ASCP standards. The LPN was re-educated on the policy and procedure for eye drop administration on March 8, 2010. Resident # 6 dietary recommendation was clarified by the Dietician on March 10, 2010. Facility staff and Resident's Physician was notified and appropriate changes were made per policy.
2. The facility reviewed all resident records to identify and ensure that any/all residents receiving eye drop medication was being administered properly. There were no issues.  
Dietician notes and summaries made during that time frame for those residents having the potential to be affected were reviewed with no issues noted.
3. The Consultant Dietician was educated on April 1, 2010, regarding consistency and accuracy of notes and summaries. The Unit Coordinator shall review all nutritional notes recorded in the medical record and also review the supplemental forms for consistency between documents prior to submitting for physician consideration.

**(CONTINUED FROM PG 11 OF 15)**

The Director of Nursing provided an educational session on April 2, 2010 with all nurses in regards to facility policy and proper administration of eye drop medications. All new nursing staff shall be oriented to the policies upon hire; and the policies shall be reviewed with nursing staff if or when a problem is identified. The Director of Nursing, or the designee, shall be notified immediately of any issues to ensure proper review and corrective measures are performed.

4. To ensure solutions are sustained in regards to the above, the Director of Nursing shall implement Quality Assurance measures to periodically review the adherence to facility policy for proper administration of eye drop medications. The Unit Coordinator will observe at least one (1) medication pass each month, for each hall; to ensure all eye drop medications are administered appropriately. The Pharmacist shall also do monthly medication pass reviews, which shall include eye drop administration observation.

To ensure solutions are sustained for accuracy and consistency of Dietary Recommendations, Quality Assurance measures shall be implemented quarterly by randomly selecting five percent (5%) of the residents reviewed by the Consultant to audit for accuracy of the system.

Evaluation reports will be distributed to the Director of Nursing for review and appropriate action taken as necessary.

5. F 281 April 2, 2010

**(CONTINUED FROM PG 12 OF 15)**

**F465 483.70(h) SAFE / FUNCTIONAL /  
SANITARY / COMFORTABLE ENVIRONMENT**

It is the policy of Letcher Manor to provide an environment that is safe, functional, sanitary and comfortable for residents, staff and the public. All personnel are formally trained and orientated on maintaining this environment.

During 2009 and 2010, this facility made major improvements and renovations to all resident rooms. Resident room furniture, new beds, new bedside tables, new bedspreads, new cubicle curtains, and new window coverings were purchased. The major improvements were that ALL resident rooms were renovated via a Contractor from September 2009 to February 2010 for any issues in the resident room, including correction of scrapes in walls, painting ceilings and walls, replacing baseboards and other areas in need. In addition, ALL doors were repaired and protective edges and kick plates were purchased and placed on all doors to prevent wear, tear and splintering. The resident rooms and doors were completely re-done, beginning September 10, 2009, and ending on December 28, 2009. There were no issues with any of the rooms on this date, or thereafter with scheduled routine maintenance. The issues noted by the Surveyor, occurred after the dates of renovation was completed, and the facility considers these issues to be a part of normal wear and tear of daily living, which are periodically monitored by the Facility Safety Committee, completion of monthly and quarterly Maintenance Checklists, and reported by formal protocol via Maintenance Requests for day to day issues.

**(CONTINUED FROM PG 13 OF 15)**

Letcher Manor's maintenance and housekeeping staff performs preventative maintenance inspections utilizing systematic routine checklists for daily, weekly, monthly, quarterly and annual checks of equipment and facilities. At the time of survey, all such routine checks had been conducted and were current. In addition, a formal maintenance request form is available for all staff to initiate for daily areas or issues in need of correction; and are designated a 'priority code' as to the urgency. These requests are addressed daily.

This is evidenced by the following actions:

1. The facility is not aware of any resident having an adverse affect from any of the issues noted during the environmental tour. All areas of observation or concern for rooms numbered 102, 106, 112, 115, 120, 128, 132, 140, 141, 145, 152 and 164 were addressed by and completed effective March 15, 2010.
2. The facility has made further environmental observation throughout the facility on all areas noted during the environmental tour. There were no further issues.
3. All staff were re-educated on March 19, 2010 and on April 2, 2010 regarding the procedures related to initiating Maintenance Request Forms and proper execution of such. Staff was also educated regarding a safe, functional, sanitary and comfortable environment and their responsibilities thereof.
4. To monitor the effectiveness of housekeeping and maintenance services, the Director of Nursing shall implement as part of the Quality Assurance process, involvement of the Safety Committee. The

**(CONTINUED FROM PG 14 OF 15)**

Safety Committee shall provide monthly inspections throughout the facility relating to safe, functional, sanitary and comfortable environment; and at random, shall select designated areas for review. The Safety Committee results, and any other environmental issues found, shall be reported to the Administrator at the time of the occurrence, so corrective measures may be taken.

5. F 485

April 2, 2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/16/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185200</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/09/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>LETCHER MANOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>73 PIEDMONT DRIVE, P O BOX 747 WHITESBURG, KY 41858</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on March 9, 2010, for compliance with Title 42, Code of Federal Regulations, 483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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.