STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185155	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Morehead	933 North Tolliver Road Morehead, KY 40351

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide effective pain management for 2 of 5 residents investigated for pain management, Resident (R) 5 and R59. The findings include: Review of the facility's policy, Nursing Documentation, dated [DATE], revealed the facility implemented interventions to prevent or manage each individual resident's pain, beginning at admission. Review of the facility's policy, Administration of Medications, dated [DATE], revealed the facility would ensure medications were administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms. 1. Review of the Closed Record revealed the facility admitted R59 on [DATE] at approximately 5:30 PM from the hospital to recover from a fall at home that resulted in a right hip fracture. Further review of the Closed Record revealed diagnoses to include peripheral vascular disease and diabetes. Review of the admission Minimum Data Set Assessment with an ARD date of [DATE] revealed the facility assessed R59 as having a Brief Interview of Mental Status (BIMS) score of 14, indicating the resident was cognitively intact. Review of the physician orders dated [DATE] revealed an order for Oxycodone 30 mg to be given every 6 hours as needed for pain. Review of progress note effective date [DATE] at 1:15 AM written by Licensed Practical Nurse (LPN) 6 revealed R59 was complaining of pain in the right hip. LPN6 wrote R59 was aware they were waiting on the pain medication to be delivered from the pharmacy. Further review revealed LPN6 administered acetaminophen 650 mg at 1:15 AM. Review of progress note effective date [DATE] at 02:08 AM written by LPN6 revealed R59 requested pain medication. LPN6 informed R59 that she would notify pharmacy and have the medication sent stat. LPN6's next sentence stated she notified the pharmacy of urgent need for medications to be delivered and the pharmacy stated they would have the medications sent by 6:00 AM or 6:30 AM. LPN 6 documented at 3:08 AM spoke with Director of Nursing (DON), informed her of what was going on. Review of progress note effective date [DATE] at 3:50 AM written by LPN6 revealed R59 was yelling out requesting pain medications. R59 was informed that the medications still had not arrived. LPN6 (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
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offered to send R59 to the emergency room (ER) for pain evaluation. R59 requested to be sent to the ER. During interview with LPN6 on [DATE] at 7:55 AM, she stated the facility admitted R59 and she could not get his pain medication because there was not another nurse in the facility with a code to access the facility's emergency medication system, so she sent him to the emergency room (ER). She further stated the Oxyconde 30 mg was available in the emergency medication system but there was not another nurse in the facility that had the code to obtain the medication and it took two nurses to enter the codes to get in the secured system. During a post-survey interview with the contracted pharmacy, on [DATE] at 2:55 PM, the pharmacist stated Oxycodone was available in the emergency medication system. During interview with the Director of Nursing (DON) on [DATE] at 10:32 AM, she stated the emergency medication system required two nurses to enter a code in order to remove medications from the system and she said the process for giving the nurses codes to access the emergency medication system was to contact the pharmacy by way of electronic mail (e-mail). She stated the pharmacy issued the codes, and any new nurse or any nurse who had an expired code was given a new code. She stated she tried to look at the list of nurses' codes and their expiration date monthly, but she was not always able to review it. She stated the importance of the codes was so nurses could access medications that were not in the medication cart. She stated, to her knowledge, there had always been two nurses in the facility who had codes to the emergency medication system. She stated, if there were not two nurses in the facility who had a code, the nurses should contact her, and she would come to the facility. 2. Review of R5's admission Record revealed the facility admitted the resident on [DATE] with diagnoses to include acquired absence of left great toe, chronic kidney disease, and type two diabetes with polyneuropathy (disorder of the peripheral nerves). Review of R5's CCP, dated [DATE], revealed the facility assessed the resident as at risk for pain in her wrist and leg related to diabetes complications. Further review revealed the facility included interventions such as administering controlled medications as ordered and providing nonpharmacologic treatments for pain. Further review of the CCP, dated [DATE], revealed the facility assessed the resident as at risk for needing more medications to achieve adequate pain relief and included interventions such as administering analgesic (pain relief) medicine as ordered and reviewing when the medication regimen was not followed as ordered. Review of R5's significant change MDS, with an ARD of [DATE], revealed the facility assessed the resident to have a BIMS score of 14 out of 15, indicating the resident was cognitively intact. Further review revealed the facility noted R5 received scheduled and as needed pain medications. Review of R5's Medication Administration Record (MAR), dated 01/2025, revealed the physician ordered 300 mg of gabapentin (a medication for nerve pain) to be administered three times per day for leg pain. Further review revealed the facility failed to administer 14 doses of gabapentin from [DATE] to [DATE], and R5 did not receive any additional pain medication during this time. Review of R5's Progress Notes, dated [DATE] at 1:54 PM, revealed Registered Nurse (RN) 5 documented sending a request for a refill for R5's gabapentin because it was running low. Per review, RN5 called the physician and the pharmacy, and the pharmacy told her the prescription was not sent in. She did not remember specifically if she followed-up after the calls because this had happened so many times. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R5's Progress Note dated [DATE] at 7:32 AM, revealed RN5 documented R5 was out of gabapentin, even though the prescription was requested on [DATE]. In an interview on [DATE] at 3:48 PM, R5 stated she recalled the facility running out of her gabapentin in 01/2025. She stated staff told her the pharmacy had not refilled her medicine, and it took days to get it fixed. R5 stated she was in pain, and she felt a shooting sensation down her leg. Per the interview, R5 did not want to complain to the nurses because she knew they were trying, but her pain was increased while she was not receiving her gabapentin. Additionally, R5 stated no staff member had suggested heat, ice, or different positions to relieve her pain. In an interview on [DATE] at 6:37 PM, RN5 stated she recalled R5 running out of gabapentin on more than one occasion, including in 01/2025. She further stated she had notified the pharmacy a week prior, when she noticed the resident's medication supply was low. Per the interview, R5's dose of gabapentin was not available in the emergency medication system. RN5 stated she did not recall R5 complaining of additional pain during that time, but the resident had received other pain medications, which helped prevent the resident's pain from getting out of control. Additionally, she stated it was important to manage the resident's pain because no one wanted to be in pain. During a post-survey interview with the contracted pharmacy, on [DATE] at 2:55 PM, the pharmacist stated gabapentin was available in the emeregency medication system. In an interview on [DATE] at 10:25 AM, the DON stated the facility's process for obtaining medication refills included faxing a refill reminder sticker to the pharmacy, submitting a request on the electronic health record, and having cycle fills of routine medications that were refilled automatically. She stated the facility had issues with getting routine medications and narcotics from the pharmacy in a timely manner. Per interview, the pharmacy the facility was currently using was new to them and they had problems with miscommunication with them. Additionally, the DON stated the facility did not have a 24-hour pharmacy in town to use as a back-up if the main pharmacy failed to deliver a medication. In an interview on [DATE] at 3:46 PM, the Executive Director (ED) stated he expected the facility to have medications available for residents as much as possible. He further stated if something happened that resulted in the medication not being available, he expected staff to call the physician and the pharmacy and get either a rush delivery or a code to obtain the medication out of the emergency medication system. He stated staff should also let the DON and himself know about the situation. The ED stated he expected residents to receive their pain medication as ordered so that their pain did not rise to uncontrollable and intolerable levels. Per the interview, the ED was not aware of R5 missing 14 doses of gabapentin in late 01/2025 and could not explain how the process failed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 1. Review of R50's admission Record revealed the facility admitted R50 on 07/08/2024 with diagnoses including [NAME]-[NAME] syndrome (a rare, autoimmune disorder in which the immune system attacked the neuromuscular junctions), type 2 diabetes, and carcinoma-in-situ of the lung. Review of R50's annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating her cognitive status was intact. Review of R50's Physician Orders, initiated on 12/13/2022, revealed an order for Pyridostigmine Bromide ER(used to improve muscle strength in patients with certain muscle diseases), 180 milligrams (mg) daily by mouth. Further review revealed it was ordered to manage the effects of [NAME]-[NAME] syndrome. Review of R50's Medication Administration Record [MAR] for April 2025 revealed she missed the dose of Pyridostigmine Bromide ER on [DATE]. Review of R50's Administration Note, dated 04/03/2025, revealed pharmacy cancelled the order for Pyridostigmine Bromide ER the previous night after Licensed Practical Nurse (LPN)1 had reordered it. Further review of the note revealed LPN1 had requested the medication be sent that day. Review of R50's MAR for May 2025 revealed she missed the doses of Pyridostigmine Bromide ER on [DATE] and 05/19/2025. Review of R50's Administration Note, dated 05/18/2025, revealed the medication was out of stock in the cart and had been reordered from pharmacy. Review of R50's Administration Note, dated 05/19/2025, revealed the medication was on order. Review of the facility's Pharmacy Calls/Notifications log revealed a call on 04/02/2025 at 9:36 AM regarding R50's missing Pyridostigmine Bromide, and the result was that the medication required Prior Authorization (PA) from the insurance company. Further review revealed a call on 05/19/2025 at 10:00 AM, with indicated response that the missing medication would be sent that evening. Continued review revealed a call on 05/20/2025 at 9:15 AM regarding the Pyridostigmine Bromide, with indicated response that it would be sent on the first run that date. Observation on 05/20/2025 at 1:58 PM, revealed R50 in bed and looking weak with a flat affect. During interview with R50 on 05/20/2025 at 1:58 PM, she stated she was very concerned about a needed medication she had not received for three days. She stated she understood the problem, and it had something to do with insurance and that it had happened before. She stated the medication was for an autoimmune condition that left her weak and unable to stand without it. Observation on 05/23/2025 at 11:46 AM revealed R50 with a much brighter affect and feeling better after the Pyridostigmine Bromide ER had been restarted. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with R50 on 05/23/2025 at 11:46 AM, she stated she felt much better today. She stated the medicine was for [NAME] syndrome, and it affected her muscles and made her not be able to stand up. She stated with the medicine her muscles worked better, and without the medicine, she was so weak she could not get up and get around. She stated she typically could get up and move with a walker but could not if she was without her medicine. She stated she had a harder time talking when she was without the medicine. She stated she felt much better today. During interview with LPN1 on 05/21/2025 at 5:22 PM, she stated the problem was the medication required a Prior Authorization (PA). She stated the facility received nine of 30 ordered pills the previous afternoon, 05/20/2025. She stated when she returned from vacation on 05/19/2025, R50 was out of the medication, so she called the pharmacy and requested a stat (immediate) delivery, but they did not send it. She also stated a PA was supposed to go to the doctor's office for them to send to the pharmacy for refilling the medication. She stated when she spoke to the pharmacy, they would tell her they needed a PA and sent the request to the physician and to the facility. In the meantime, she stated, staff had requested from the Administrator or Director of Nursing (DON) to pay for the short-term refill pending the authorization being approved. LPN1 stated they normally ordered refills directly through the electronic heath record (EHR). But for this medication, she stated the pharmacy notified the provider but would call the facility if the PA was not received. She stated sometimes pharmacy sent that to the facility as well, and those would be taken to the DON. During interview with LPN6 on 05/22/2025 at 8:24 AM, she stated if a medication was not stocked in the cart, she ordered it right then through point-click-care (PCC), a software the facility used. However, she stated when she ordered at night, then it still might not be in when she returned to work, and she had to call again. She stated the facility had a telephone log for pharmacy calls so anybody who followed the nurse who ordered a given medication could see it on the computer, and it should have been on the log. During interview with LPN2 on 05/22/2025 at 1:21 PM, she stated when R50's Pyridostigmine Bromide ER was received, the manifest indicated the pharmacy sent nine pills, and owed 21. She stated she ordered medicines directly through PCC, and also took the sticker off the medication box and added that to a list of stickers on a paper form, and then faxed it to the pharmacy. She stated she usually ordered refills three to four days out from being out of the medication. LPN2 stated, if knowing from the past that a medication was difficult to get, she would order earlier. She stated if a medication required a PA, she might not be aware of that as those were managed on day shift, but if alerted for such, the day nurse called the doctor for that. She stated when putting in orders, the only alert from the screen were possible interactions. She stated there was not an alert if the medication required a PA, and that information would come from a pharmacist. LPN2 also stated she knew at least two other nurses who used the added step of faxing the stickers. During additional interview with LPN1 on 05/22/2025 at 5:26 PM, she stated the facility had received the remainder of ordered pills for R50. She stated PAs were previously not a problem, and a PA was in effect for a year. However, she stated after 01/01/2025, that had changed, and now a PA was required every month. She stated the pharmacy had reported they had sent the PA to the physician, but the facility had not received a response. She also stated she started having more problems with this in April 2025, and the facility had paid for the medicine since then. During interview with the Staff Development Coordinator (SDC) on 05/22/2025 at 2:39 PM, she stated the facility provided education on medication management if there was a complaint. For example, she stated if there was a complaint that came up at the morning staff meeting, the DON asked for (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	education for that issue, then she would develop a review with the policy for the staff. She stated staff nurses kept up with medication management. She stated she did not do specific education on reordering, that came with assistance from their preceptor. During interview with the contracted Pharmacist on 05/22/2025 at 10:08 AM, he stated Pyridostigmine Bromide orders required a PA. He also stated there was an attempt to refill on 05/18/2025, and the non-covered authorization form was completed. He stated this form was necessary because insurance would not pay, so either the facility could pay or work to get an alternate medication. He stated the medication was not covered, but he did not know why and could not say if this was a permanent issue. He stated all he could say was a PA was required as evidenced by a PA documented as requested on 05/13/2025. He stated the methods to pursue included using an interface from another pharmacy for review of issues. He stated he had been working on the communication process. He stated the pharmacy's Clinical Intervention Center generated the PA, which then went to the physician or facility per the facility's preference. He stated for this facility, he could not say the process but agreed to reach out to the Clinical Intervention Center and request they call. During additional interview with the Pharmacist on 05/23/2025 at 9:01 AM, he stated for this facility, PA notifications went to an interface from another pharmacy, and also generated a fax to the facility. He further stated the PA could go to the provider if a facility chose. For this facility, he stated, a PA went to a fax number in the facility but was changed to a different fax number last week per request of the DON. The Pharmacist stated R50's medication was ordered on 05/13/2025, kicked to the Clinical Intervention Center due to the PA and nonpayment without it. In turn, he stated it generated a notice of the needed PA to OCC, which the facility could have access to, and generated a fax to the selected number. He stated the facility could see OCC with their own login, so a nurse or manager would have to do that manually on that website. He stated the website could have alerts sent via email, but the alerts could not be seen in PCC. During interview with the DON on 05/23/2025 at 10:19 AM, she stated when she talked to the pharmacist last week, she learned when a medication required a PA, if the pharmacy would notify the facility, the facility would pay for a short supply pending the PA approval. She stated the current strategy was for the pharmacy to notify the facility of a PA by fax. In the past, she stated the pharmacy had a staff member who included PA notices on paper on the midnight delivery, so the facility would have it in hand the following morning. She stated the paper PA notices stopped maybe six months ago, but she was not sure of the exact timeframe. She stated she had an in-person meeting with the Pharmacist, when they went over the interface from another pharmacy together, but the links did not take them to relevant information or the system crashed. Since then, she stated the pharmacy had been sending the notices by fax. She also stated the facility had only a few residents who were taking medications which required a PA, such as something insurance would not cover, so the facility paid for those. She further stated the pharmacy sent the PA, and the DON completed the form. She stated, then Medical Records staff took the PA to the provider or they obtained the signature when the provider was in the building. Then, she stated the facility sent the PA back to the pharmacy. During additional interview with the DON on 05/23/2025 at 2:44 PM, she stated she called the pharmacy when she was no longer receiving PA notices on paper. She stated the pharmacy told her those staff members were no longer there, and they did not offer an explanation or how they were to transmit those. After that, she stated a notice would show up on a random basis, and she assumed there was nobody on a medication that required a PA. She stated she and another nurse manager were the only ones who had access to the interface from another pharmacy, but the floor nurses did not and would not have received the notices. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview with the Executive Director on 05/23/2025 at 3:11 PM, he stated if there were problems with getting residents' medications, he expected staff to alert the provider and work with pharmacy. He stated, if the issue was still not resolved, he expected staff to contact him or the DON, and they could contact the Regional Pharmacist directly. He stated he expected if those actions did not resolve the problem, then the facility could source the medication from a retail pharmacy.2. Review of R5's admission Record revealed the facility admitted the resident on 01/25/2023 with diagnoses at time of survey including acquired absence of left great toe, chronic kidney disease, and type two diabetes with polyneuropathy (disorder of the peripheral nerves). Review of R5's significant change MDS, with an ARD of 04/16/2025, revealed the facility assessed the resident to have a BIMS score of 14 out of 15, indicating the resident was cognitively intact. Further review revealed the facility noted R5 received scheduled and as needed pain medications. Review of R5's MAR, dated 01/2025, revealed the physician ordered 300 mg of gabapentin (a medication for nerve pain) to be administered three times per day for leg pain. Further review revealed the facility failed to administer 14 doses of gabapentin from 01/12/2025 to 01/30/2025. Review of R5's Progress Note, dated 01/10/2025, revealed Registered Nurse (RN) 5 documented sending a request for a refill for R5's gabapentin because it was running low. Per review, RN5 called the physician and the pharmacy, and the pharmacy told her the prescription was not sent in. Review of R5's Progress Note, dated 01/17/2025, revealed RN5 documented R5 was out of gabapentin, even though the prescription was requested on 01/10/2025. In an interview on 05/23/2025 at 3:48 PM, R5 stated she recalled the facility running out of her gabapentin in 01/2025. She stated staff told her the pharmacy had not refilled her medicine, and it took days to get it fixed. R5 stated she was in pain and felt a shooting sensation down her leg. Per interview, R5 did not want to complain to the nurses because she knew they were trying, but her pain was increased while she was not receiving her gabapentin. In an interview on 05/23/2025 at 6:37 PM, RN5 stated she recalled R5 running out of gabapentin on more than one occasion, including in 01/2025. She further stated she had notified the pharmacy a week prior, when she noticed the medication supply was low. Per interview, R5's dose of gabapentin was not available in the facility's emergency medication system. In continued interview, RN5 stated on multiple occasions, she had notified the physician of the need for a refill prescription and would call the pharmacy to follow up on a refill. She stated the pharmacy would tell her they did not have it, even though the physician told her they sent it in. Additionally, RN5 stated a delivery requested as STAT (as quickly as possible; high priority) would often not arrive for 10 hours from the pharmacy. During a post survey interview with the contracted pharmacy, on 06/10/2025 at 2:55 PM, the pharmisist stated that gabapentin was available in the emergency medication system at the facility. In an interview on 05/22/2025 at 10:25 AM, the Director of Nursing (DON) stated the facility's process for obtaining medication refills included faxing a refill reminder sticker to the pharmacy, submitting a request on the electronic health record, and having cycle fills of routine medications that were refilled automatically. She further stated staff could request a rush delivery from the pharmacy or pull the medication from the emergency medication system with an access code from pharmacy. In continued interview, the DON stated the facility had issues with getting routine medications and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	narcotics from the pharmacy in a timely manner. Per interview, the pharmacy the facility was currently using was new to them, and they had problems with miscommunication with them. Additionally, the DON stated the facility did not have a 24-hour pharmacy in town to use as a back-up if the main pharmacy failed to deliver a medication. In an interview on 05/23/2025 at 3:46 PM, the Executive Director stated he expected the facility to have medications available for residents as much as possible. He further stated if something happened that resulted in the medication not being available, he expected staff to call the physician and the pharmacy and get either a rush delivery or a code to obtain the medication out of the emergency medication system. In continued interview, he stated the facility noted the communication barriers with pharmacy on 05/12/2025 around admission and readmission, as well as not receiving refills. Per interview, he stated he was not aware of R5 missing 14 doses of gabapentin in late 01/2025. Based on observation, interview, record review, and review of the facility's policies, the facility failed to provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement. The facility failed to provide pharmaceutical services (including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 of 5 residents investigated for pharmacy services, Resident (R) 5 and R50. The findings include: Review of the facility's policy, Reordering, Changing, and Discontinuing Medication Orders, revision date 7/01/2024, revealed facilities are encouraged to reorder medications electronically or by fax whenever possible staff may use electronic orders. Facility staff [the pharmacy's software program, secure web portal for pharmacy management, communication, and reporting] log in [the pharmacy's software program] to access medication, order status, payment and more. [The pharmacy's software program] should be restricted by assigned user identification and password and should be controlled by the Director of Nursing or designee. Further review revealed facilities were encouraged to reorder medications electronically or by fax whenever possible, and the reorders would be written and submitted on the pharmacy's Refill Order Form and would be faxed to the pharmacy, if permitted by applicable law. Continued review revealed authorized facility staff would use the software to electronically reorder resident medications, and staff should review the transmitted reorders for status and potential issues and pharmacy response. Review of the facility's policy titled, Nursing Documentation, reviewed 09/05/2024, revealed the facility implemented interventions to prevent or manage each individual resident's pain, beginning at admission. Review of the facility's policy titled, Administration of Medications, reviewed 09/16/2024, revealed the facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms.