STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155691	A. Building B. Wing	04/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morristown Manor	868 S Washington St Morristown, IN 46161

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 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. 41129 Based on observation, interview and record review, the facility failed to ensure proper medication administration procedures were followed by preparing medications for more that one resident at a time during medication administration for 2 of 2 medications carts reviewed for the prepping of medications for multiple residents. (Facility) Findings include: An observation of the Pine and Juniper units medication carts was conducted on 4/18/24 at 7 p.m. The following was observed: 1. The Pine unit's medication cart was reviewed with QMA (Qualified Medication Assistant) 2. QMA 2 unlocked the medication cart and in the top drawer there two medication cups with medications in them. QMA 2 indicated, one of the medication cups contained medications for Resident Q but when she went to administer the resident her medications she was not available to take her medications. QMA 2 also indicated, the other medication cup with medications inside it were for Resident R. When asked how many residents at a time can they prepare medications ahead of time for she indicated, none. QMA 2 then identified the medications inside each cup for the respective residents. a. Resident Q's medication cup contained the following medications: Tramadol (pain medication), gabatentin (nerve pain medication), acetaminophen, atorvastatin (cholesterol- reducing medication), Lasix (diuretic), melatonin (sleep aid), pramipexole (Parkinsons and/or restless leg medication) and Xarelto (anti-coagulant). b. Resident R's medication cup contained the following medications: Aptiom (seizure medication), Lasix, oyster shell calcium (supplement), lamotrigine (mood stabilizer). 2. Immediately following the Pine unit's medication cart, the Juniper unit's medication cart was reviewed with LPN (Licensed Practical Nurse) 3. LPN 3 unlocked the medication cart and in the top drawer were 5 medication cups containing medications for multiple residents. LPN 3 then identified who the prepared medications belonged to and what medications were in each cup as follows: a. Resident S's medication cup contained: buspirone (anti-anxiety medication), diltiazem (blood pressure medication), Trazadone, Xanax (anti-anxiety medication) (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident T's medication cup contained: depakote (anti-seizure, bipolar medication), and senna (laxative) c. Resident U's medication cup contained: atorvastatin, buspirone, carvedilol (blood pressure medication), Lasix, melatonin, oyster shell calcium, and acetaminophen d. Resident V's medication cup contained: buspirone, coreg (blood pressure medication), Cymbalta (antidepressant/nerve pain medication) and Norco (pain medication) e. Resident X's medication cup contained: buspirone and tramadol A QMA Responsibilities policy was received on 4/19/24 at 12:01 p.m. from DON (Director of Nursing). It indicated, Other considerations and Reminders .NO presetting of medication The facility did not have an Administration of Medication policy per DON but instead followed the Licensed Nurse Med Pass Clinical Skills Validation. This Federal tag relates to Complaint IN00431737. 3.1-25(b)(5)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41129 Based on observation, interview, and record review, the facility failed to ensure controlled medications stored in the facility's locked medication storage drawer in the medication refrigerator inside the main medication room were labeled with an opened date and a label which at a minimum includes the medication name (generic and/or brand), prescribed dose, strength, the expiration date when applicable, the resident's name, and route of administration for 2 of 4 resident's medications reviewed for medication storage. (Resident C and P) Findings include: A medication storage observation of the facility's main nursing station medication room was conducted on 4/18/24 at 7:23 p.m. with DON (Director of Nursing). With the medication room was a medication refrigerator which contained a locked metal box which held controlled medications. Inside the locked controlled medication drawer the following was observed: 1. An opened box containing a multi-dose bottle of lorazepam (anti-anxiety medication) which had also been previously opened. On the medication box was a handwritten name in black marker. DON indicated the name written on the box was the last name of Resident C. Neither the box nor the opened bottle of medication inside the box had a pharmacy label affixed with the resident's full name, the prescribed dose, or the route of administration. 2. An opened box containing an opened multi-dose bottle of lorazepam liquid. On the medication box was Resident P's name handwritten in black marker. Neither the box nor the opened bottle of medication inside the box had a pharmacy label affixed with the resident's full name, the prescribed dose, or the route of administration. An interview with DON conducted at the same time as the observation indicated, the medications mentioned above were obtained from the facility's medication management machine and not from the pharmacy. A Medication Labeling policy received on 4/19/24 at 9:59 a.m. from DON indicated, All labeling of prescriptions filled by [pharmacy's name] will be the responsibility of the dispensing pharmacist and will be consistent with State and Federal requirements. Labeling of prescription for outside pharmacies will also be according to State and Federal regulations. Labeling of over the counter drugs NOT dispensed by [pharmacy's name] are the responsibility of the outside pharmacy or the facility Medications Administered by Authorized Staff .shall be labeled as follows . a. Name of Drug b. Route of administration, if other than oral c. The strength and volume . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. The control number and expiration date e. Identification of the manufacturer, [NAME] or pharmacy f. Prescription number g. Special storage conditions . 2. Multiple dose drug distribution systems that dispense single unit packages require the label to contain the following a. Identification of the pharmacy b. Resident's name c. Date of dispensing d. Non-proprietary and/or proprietary name of the drug e. Strength expressed in the metric system whenever possible . 3.1-25(j) 3.1-25(k)