

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/10/2024
NAME OF PROVIDER OR SUPPLIER Claiborne Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Buchanan Rd New Tazewell, TN 37825	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36003</p> <p>Based on facility policy review ,medical record review, facility documentation review and interviews, the facility failed to protect 1 resident (Resident #12) from abuse of 19 residents reviewed for abuse.</p> <p>The findings include:</p> <p>Review of the facility's undated policy titled, Freedom from Abuse and Neglect Policy, revealed .Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish .Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Types of abuse may include: A. Physical assault or abuse 1. Hitting 2. Slapping .All residents will be protected from harm .</p> <p>Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Major Depressive Disorder and Dementia with Psychotic Disturbance.</p> <p>Review of the comprehensive care plan for Resident #12 dated 4/7/2023, revealed the resident had wandering behaviors.</p> <p>Review of a significant change Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #12 had severe cognitive impairment. Continued review revealed the resident exhibited physical and verbal behaviors toward others.</p> <p>Review of the Nurse's Note for Resident #12 dated 12/8/2023 at 7:12 AM, revealed .Resident [#12] was witnessed by [Certified Nursing Assistant-CNA B] to be struck multiple times in bilateral [both] arms and right lower jaw by another resident [Resident #21]. CNA B intervened to remove the resident [Resident #12] from the room. Resident [#12] has no visible injuries . The resident was assisted to the dining room where she watched television.</p> <p>Review of the facility document titled, Body Audit (skin assessment) for Resident #12 dated 12/8/2023, revealed the resident had no injuries.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Medical record review revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including Dementia with unspecified severity, with Other Behavioral Disturbance and Schizoaffective Disorders.</p> <p>Review of the comprehensive care plan for Resident #21 dated 6/8/2023, revealed the resident had aggressive behaviors.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #21 was moderately cognitively impaired. Continued review revealed the resident exhibited physical and verbal behaviors toward others .</p> <p>Review of a Nurse's Note for Resident #21 dated 12/8/2023, at 7:04 AM, revealed .Resident [#21] was witnessed by CNA B to strike another resident multiple times in bilateral arms. She also struck the other resident in the lower jaw. [CNA B] intervened to remove the other resident [Resident #12] from the room and the resident [#21] proceeded to try and strike [CNA B] .Notified [Unit Manager] my immediate supervisor of the situation, Assesed [assessed] the resident [#21] she is in her room .</p> <p>Review of the facility document titled, Body Audit for Resident #21 dated 12/8/2023, revealed the resident had no injuries.</p> <p>During an interview on 5/7/2024 at 3:57 PM, CNA B stated she heard a noise coming from Resident #21's room. CNA B stated Resident #12 had wandered into Resident #21's room and was standing at the end of Resident #21's bed with her arms folded. Continued interview revealed Resident #21 was swinging her arms, hitting Resident #12's arms. Continued interview revealed CNA B separated the residents and reported the incident to the charge nurse.</p> <p>During an interview on 5/9/2024 at 12:42 PM, the Assistant Director of Nursing confirmed the altercation between Resident #12 and Resident #21 occurred.</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35460</p> <p>Based on facility policy review, medical record review, facility documentation review, observation and interviews, revealed the facility failed to ensure 1 resident (Resident #6) received adequate supervision to prevent elopement (a situation which involves a resident leaving the premises or safe area without necessary supervision) from the premises of 7 sampled residents reviewed for accidents. On 6/18/2024, at approximately 4:15 PM, the facility staff were unable to locate Resident #6. The resident remained out of staff supervision for 1 hour and 12 minutes. The facility's failure to provide adequate supervision placed Resident #6 and 20 other residents, identified as having the potential for elopement, at risk for Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident).</p> <p>The Administrator, Director of Nursing (DON), and [NAME] President of Clinical Operation (VPCO) were notified of the Immediate Jeopardy on 5/10/2024 at 10:45 AM in her office.</p> <p>The facility was cited Immediate Jeopardy at F-689.</p> <p>The facility was cited Immediate Jeopardy (IJ) at F-689 at a scope and severity of J which constitutes Substandard Quality of Care.</p> <p>The IJ began on 6/18/2023 and continued through 6/22/2023. The facility's corrective actions were completed on 6/22/2023.</p> <p>An acceptable Allegation of Compliance for the past non-compliance, which removed the immediacy, was provided by the facility on 5/10/2024 and was validated on site.</p> <p>The IJ was cited as past noncompliance for F-689 and the facility is not required to submit a Plan of Correction.</p> <p>The findings include:</p> <p>Review of the facility policy, Elopement Management Program, dated 12/26/2016 revealed .A system that addresses a resident's risk of elopement from the premises or safe area without authorization and/or necessary supervision to do so .</p> <p>Medical record review revealed Resident #6 was admitted to the facility's secure unit on 6/16/2023 with diagnoses including Pneumonia, Dementia, and Delusional Disorders.</p> <p>Review of an Elopement Risk assessment dated [DATE], revealed Resident #6 was assessed to be at risk for elopement due to his Dementia, comments about wanting to go home and exit-seeking behaviors.</p> <p>Review of a Brief Interview for Mental Status (BIMS) assessment dated [DATE], revealed Resident #6 scored a 2, which indicated the resident had severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility documentation dated 6/18/2023, showed Resident #6 exited the secure unit at approximately 3:30 PM, by following a visitor out the secure unit door. The resident walked down the hallway and the front door camera showed the resident followed a group of visitors out the main entrance doors on 6/18/2023 at 3:37 PM. Continued review revealed Resident #6's son entered the facility and was unable to locate the resident. The facility staff were notified and searched the secure unit. When Resident #6 was unable to be located, a Code Pink (all staff conduct a head count of their residents and search for the missing resident throughout the facility) was initiated. Further review revealed a Certified Nursing Assistant (CNA) D drove her car and looked for the resident. Resident #6 was located at a gas station 1.1 miles away from the facility. The resident returned to the facility with CNA D in her car at approximately 4:15 PM. The resident was assessed for injury, none noted, and was placed with 1:1 supervision.</p> <p>Review of a nurse's note dated 6/18/2023, revealed the physician had ordered Resident #6 be placed with 1:1 supervision post elopement.</p> <p>During an interview on 5/7/2024 at 10:00 AM, Licensed Practical Nurse (LPN) B stated she was not working the day Resident #6 eloped from the facility. Continued interview revealed, after she returned to work the following day, Resident #6 received 1:1 supervision and all the codes to the keypads in the facility were changed. LPN B stated the staff was not allowed to give the codes to anyone except for Emergency Services Technicians.</p> <p>During a telephone interview on 5/9/2024 at 8:45 AM, CNA C confirmed she was working the day Resident #6 eloped from the facility and thought he must have followed a family member out of the secure unit. Continued interview revealed before the elopement, family members were allowed to have the access codes for the keypads.</p> <p>During an interview on 5/9/2024 at 1:15 PM, the DON and the Assistant Director of Nursing (ADON) revealed they had watched the camera footage which showed a time stamp of 3:37 PM, when Resident #6 exited through the main entrance doors. The resident was located and returned to the facility at 4:45 PM (approximately 1 hour and 12 minutes) after he eloped.</p> <p>During a telephone interview on 5/10/2024 at 8:30 AM, CNA D revealed Resident #6's son asked her if she knew where his father was and the CNA checked his room and the shower. The CNA then reported to her co-workers Resident #6 could not be located and they searched the secure unit. The CNA stated the nurse called a Code Pink and CNA D got in her car, drove around a housing development across the street and continued down the road. Continued interview revealed she saw the resident standing in the parking lot of a gas station and asked the resident if he would like something to drink, he said yes, got into the car with her, and she drove him back to the facility.</p> <p>The facility's corrective actions for the removal plan were issued to the surveyor on 5/10/2024. The corrective action plan included the following:</p> <p>1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility held a Quality Assurance Performance Improvement meeting on 6/18/2023 which determined the root-cause analysis to be Resident #6 had followed a visitor out of the secure unit and then followed another group of visitors out the main entrance doors. The following facility staff members attended the QA meeting: Administrator, DON, Nurse Consultant, Assistant Director of Nursing, Unit Managers, Activities Director, Business Office Manager, and the Medical Director by phone.</p> <p>2. How the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>On 6/18/2023-6/19/2023, all residents were reassessed for elopement risk by the Director of the Secure Unit, ADON, and Unit Manager (UM). There were 20 residents at risk for elopement with no new residents identified.</p> <p>On 6/18/2023, all the doors in the facility were checked to ensure they were locked, secure, and functioning properly by the Maintenance Director. There were no concerns identified.</p> <p>On 6/19/2023, the facility conducted a 30-day look back of nurses' notes, the electronic medical record, and the 24-hour report log to identify residents for exit seeking behaviors, wandering or comments of wanting to leave the facility. A review of the elopement binders, located at each nursing station, was completed by the Nurse Consultant, DON, ADON, and UM.</p> <p>On 6/19/2023, facility Administrator, DON, UM, ADON, Social Services Director, Admissions Director, Dietary Manager, Minimum Data Set (MDS) Coordinators, Maintenance Director, Business Office Manager, Director of Care Coordination, Rehabilitation Manager, Dietary Manager, and Activities Director were educated by the facility's Nurse Consultant on policies, procedures, and processes. The training included: Elopement, Missing Resident, Door codes/alarms, Accident/Incident, Safety and Supervision, Implementation of Interventions and Resident Rights. The training was performed face to face to facilitate discussion and questions. Department administrative managers could not return to work until the education was provided, post-test administered related to elopement policy and procedures and 100% score obtained. If a manager did not score 100% on the post-test, the manager was immediately re-educated and post-test re-administered. This process continued until all managers obtained a 100% score on the post-test. All post-tests were reviewed for compliance by the Nurse Consultant.</p> <p>Continued education was conducted either in person or by phone with all other staff, completed 6/22/2023. If a staff member was not available to attend the education, they were to be provided the education prior to their next shift worked. The process was monitored by each department head.</p> <p>3. What measures will be put into place or systemic changes to ensure the deficient practice will not reoccur?</p> <p>On 6/19/2023, the facility conducted a Code Pink drill daily on both shifts and continued to do so for 1 week. The drills continued for 4 weeks and then quarterly on various shifts and days.</p> <p>The facility implemented Guardian Rounds (walking rounds with visual observations done throughout the facility, observing for an increase in behaviors/wandering/exit seeking for residents) to be completed daily by department managers and the Manager on Duty for the weekends.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Removal Plan was validated onsite by the surveyor on 5/10/2024, which included review of the facility documentation to show each step had been completed and facility staff interviews.</p> <ol style="list-style-type: none"> 1. Progress notes showed Resident #6 was discharged to a Psychiatric hospital on 8/8/2023 and did not return to the facility. 2. Review of a QAPI meeting sign-in sheet dated 6/18/2023 and interview with the DON/ADON confirmed the facility met and completed a root cause analysis. 3. Review of a facility document dated 6/18/2023 and interview with the Maintenance Director confirmed he checks all the doors daily for functionality and the doors are checked on weekend by the assigned department head designated as the Weekend Manager. 4. Review of the documentation of the drills and interviews with the Maintenance Director and Administrator confirmed the drills were ongoing and were being reviewed in the QAPI meetings. 5. Review of a census roster dated 6/18/2023 with the title Elopement Risk Evaluations written on the top of the document and interview with the DON/ADON confirmed the elopement assessments for all residents were completed by 6/19/2023. 6. Review of handwritten statements dated 6/18/2023-6/19/2023 and interview with the DON/ADON confirmed the 30-day look back was completed for all residents with no unidentified concerns. 7. Review of a sign-in sheet along with a copy of all policies, procedures, processes, and interviews completed throughout the complaint survey conducted on 5/6/2024-5/10/2024 revealed all staff were aware of the elopement management, Code Pink, where to find the elopement risk binders, and they were not to give the access codes to anyone, other than a co-worker to the facility doors. <p>Interviews conducted on 5/10/2024 with 2 nurses and 3 CNAs assigned to the secure unit, confirmed the staff were aware of the location of the elopement binders, what to do for a Code Pink, and the keypad codes were not given to family members.</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30647</p> <p>Based on review of facility policies, medical record reviews, review of facility investigations and interviews, the facility failed to maintain controls (chain of custody) on narcotic inventories which resulted in diversion of narcotic stocks for 3 of 20 residents (Residents #4, #9, and #35) of 20 residents sampled for misappropriation, of 35 sampled residents.</p> <p>The findings include:</p> <p>Review of the facility's, Medication Disposal and Returns Policy, effective 6/21/2017, showed .Nursing staff is responsible for removing all discontinued medications from the cart and/or storage areas. Full chain of custody should be documented to clearly indicate the removal of the medication from the cart and placed into a secure storage area for destruction .Two individuals .shall witness and document the destruction in the format required per the applicable state regulations .follow State Regulations regarding the timing of the destruction .Controlled substances not authorized by the physician for release to the resident at the time of discharge are to be destroyed .</p> <p>Review of the facility policy, Controlled Substances, Administration of Schedule 2 Controlled Medications, effective 6/21/2017, showed, .Administration of Scheduled Controlled Substances will be consistent with the policies for general medication administration with the additional requirement of logging all doses on the individual residents [Controlled Drug Receipt/Record/Disposition Form] All scheduled controlled medications removed from storage .will be entered onto the individual Resident's Controlled Drug Receipt/Record/Disposition Form .Any Discrepancies .must be immediately reported to the Director of Nursing .The facility shall maintain a record and signed scheduled medication count at each change of shift . by on-coming nurse .with off-going nurse .using facility approved form .Any discrepancies in the [shift count] must be immediately reported to the Director of Nursing for further action .</p> <p>Medical record review showed Resident #4 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Presence of Right Artificial Hip Joint, Adult Failure to Thrive, Unspecified Psychosis, Chronic Obstructive Pulmonary Disease and Generalized Anxiety Disorder.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE], showed Resident #4 had a Brief Interview of Mental Status Score of 0/15, which indicated Resident #4 was severely cognitively impaired. Resident #4 had impaired thought processes, symptoms of delirium and was dependent upon one or two persons for all activities of daily living.</p> <p>Review of Physician Orders and the December 2023 Medication Administration Records showed Resident #4 was prescribed Morphine Oral Solution (a narcotic) 10 milligrams (mg) per 0.5 milliliters (ml) every 2 hours as needed for pain.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility investigation showed on 12/21/2023 Licensed Practical Nurse D (oncoming nurse) assumed care of Resident #4 after completion of the shift change medication cart narcotic reconciliation process around 6:00 PM. LPN D counted the narcotic inventories and signed off that all narcotic inventories were correct with LPN E, (the off-going nurse). Continued review showed around 9:00 PM (3 hours later) LPN D became suspicious the narcotic count previously performed was not accurate and asked another nurse (Registered Nurse, RN B) to recheck the narcotic inventories on the cart with attention to morphine supplies on hand for Resident #4, at which time, it was discovered the morphine inventory was actually 7.5 ml short (equal to 35 mg of morphine) of what was documented to be on hand. LPN D notified the Director of Nursing who verified the morphine supply documented on the facility Narcotic Reconciliation Forms was inaccurate and launched an investigation.</p> <p>Continued review of the facility investigation and witness statements revealed the following:</p> <p>-LPN E did not contact the facility for 7 days during the investigation, despite multiple attempts to reach her, and when eventually contacted, categorically denied misappropriation of the missing morphine and noted LPN D had counted the medication at shift change on 12/21/2023 and signed documentation that the count was correct at that time.</p> <p>-LPN D denied misappropriation and reported at that time during the shift count with LPN E, she expressed concerns to LPN E, the morphine inventory for Resident #4 appeared short but was assured by LPN E it was accurate and appeared short due to LPN E's failure to document missing doses given that morning, which LPN E reported to LPN D she would immediately correct.</p> <p>-LPN D did not stop the count, and report irregularities to the Director of Nursing at once.</p> <p>-LPN D discovered 3 hours later, LPN E had made no changes to the facility Narcotic Reconciliation Logs as she had promised, and there was no documentation of morphine administration to Resident #4 in the electronic records that day (MAR), during LPN E's shift, then reported the irregularity to the DON.</p> <p>-LPN E denied she made such statements to LPN D and categorically denied wrongdoing. Continued review of the investigation showed the missing morphine was never recovered, nor could the facility accurately identify when the missing morphine was misappropriated, or by whom and neither employee involved in the 12/21/2023 incident underwent drug testing in response to the incident.</p> <p>Medical record review showed Resident #9 was admitted to the facility on [DATE] with diagnoses including Presence of Left Artificial Hip Joint, Sacral Osteomyelitis, Left Hip Pain and Disruption of Surgical Wound.</p> <p>Review of the quarterly MDS dated [DATE], showed Resident #9 with a BIMS of 13/15 which indicated the resident was cognitively intact. Resident #9 required assistance of one or two persons for ADLs.</p> <p>Review of Resident #9's medical record showed he was discharged from the facility 3/2023.</p> <p>Medical record review showed Resident #35 was admitted to the facility on [DATE] and readmitted [DATE] with diagnoses including Left Femur Fracture, Encounter for Surgical Aftercare of the Digestive System, Chronic Pain, Unspecified Dementia and Sepsis.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the quarterly MDS dated [DATE], showed Resident #35 had a BIMS of 13/15 which indicated the resident was cognitively intact. Resident #35 required assistance of one person for activities of daily living.</p> <p>Review of the facility investigation dated 3/27/2023, showed on that date, the following:</p> <ul style="list-style-type: none"> -The facility was contacted by a former employee who had left employment with the facility in 1/2022. -The former employee informed the facility she was landlord to a current employee (CNA B). -The former employee reported she had evicted CNA B from the property she rented to her and while clearing CNA B's possessions from the property, discovered multiple cards of controlled substances, in their original packaging from the nursing home, for multiple residents, all dated between June 2022 and August 2022. -The former employee reported to the facility she summoned law enforcement to the residence and local police had launched an investigation. -Continued review of the facility investigation and witness statements revealed CNA B categorically denied misappropriation of the medications during interviews with both police and the facility and denied knowledge of how they came to be found on the property she rented from the former employee. -The facility investigation also revealed all medications recovered by police were discontinued medications that had been slated for destruction at the facility when they were diverted, and police had discovered them with their corresponding Controlled Drug Receipt/Record/Disposition Forms attached to the cards. -The facility investigation failed to identify a potential alleged perpetrator (As CNA B had no access to secured areas where drugs were stored pending disposal). -The facility failed to identify how/when the discontinued medications had gone missing in the first place, or how the misappropriation of discontinued narcotics went undetected by the facility or it's pharmacy provider when drugs were destructed. <p>Review of the police report showed, in total, local law enforcement recovered 7 (name of narcotic) 5 mg tablets, 34 (name of nerve pain medication) tablets, 19 (name of benzodiazepine) 2 mg tablets, 19 (name of narcotic) 10 mg tablets, 9 (name of another benzodiazepine) 0.5 mg tablets, and 2 (name of sleeping medication) 5 mg tablets.</p> <p>Local police ruled out the former employee as a suspect, based on dates on the prescriptions, found during their investigation. The former employee had not worked at the facility in the prior 6 months to the time the controlled substances were stolen from the facility and had no access to the facility, residents, or medications. The law enforcement investigation remained open and ongoing at the time of the State Agency Survey.</p> <p>Review of a facility investigation dated 11/18-20/2023, showed the following:</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-On 11/18/2023, around 10:30 AM, the facility Director of Nursing (DON) observed an on-duty staff member (LPN F) and spoke with her as the DON escorted a group of residents to a local holiday parade. At that time, nothing appeared [NAME].</p> <p>-Continued review showed around 2:10 PM, upon return to the facility, the DON was informed by the unit manager LPN F was not feeling well and despite offers to be sent home by the unit manager, LPN F had declined. At that time, LPN F reported she had a migraine but showed no signs of impairment and was allowed to remain on-duty.</p> <p>-Continued review showed at 2:51 PM, the DON was informed by floor staff LPN F appeared impaired, with glossy eyes and she was falling over.</p> <p>-The DON was summoned to the floor and removed LPN F from the unit. LPN F struggled to ambulate to the business office without assistance.</p> <p>-At 3:05 PM, LPN F was questioned about substance abuse and denied it. LPN F was advised to submit a urine sample for drug testing. LPN F stated she was unable to provide a sample due to toileting earlier. LPN F was given a soda to drink so she could provide a urine sample.</p> <p>- Shortly after that, LPN F became obtunded, dozed off in the chair, then spilled her drink on herself.</p> <p>-After that, LPN F was aroused by observers, attempted to give a urine sample and was observed as she put water in the urine sample container for testing by observers.</p> <p>-LPN F exhibited hallucinations and stated there was water in the floor not visible to those observing her, her speech became incoherent. She initially refused transportation to a local hospital, citing her lack of health insurance.</p> <p>-The facility attempted to contact LPN F's spouse without success. At 3:55 PM, the DON and Unit Manager transported LPN F to a local hospital by private vehicle for evaluation as LPN F's mental status was obviously altered. LPN F required assistance to be transferred from a private vehicle into the emergency room (ER) and was mentally obtunded to the point she could not give accurate information to ER staff.</p> <p>- LPN F underwent drug testing in the ER where she tested positive for [names of 3 narcotic medication], received 3 doses of [name of the narcotic antagonist to reverse opioid effects on the central nervous system] and was admitted for further treatment.</p> <p>Further review of the facility investigation showed on 11/18/2023, the physician in the ER, informed the facility it appeared LPN F had overdosed on opioids. The facility conducted an audit of narcotic stocks on LPN F's medication cart and discovered multiple discontinued narcotics from a resident, who had passed away the day prior, remained stored on the cart, not disposed of, which included a vial of morphine sulfate 20 mg/ml concentration, which had 4 ml of the medication missing, (equal to 80 mg of morphine) which was unaccounted for on the corresponding Controlled Drug Receipt/Record/Disposition Form. All other medications on the cart were accounted for.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/10/2024
NAME OF PROVIDER OR SUPPLIER Claiborne Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 902 Buchanan Rd New Tazewell, TN 37825	
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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 5/9/2024 at 2:10 PM, the DON confirmed the facility had experienced multiple incidents of narcotic diversion over the prior year, which the facility identified as related to the disposition of discontinued medications, slated for destruction, which were not promptly removed from the medication carts and placed in a designated lock box to await destruction or failure of floor nursing staff to ensure the Controlled Drug counts were accurate at shift change.</p>		