

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445246	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/10/2025
NAME OF PROVIDER OR SUPPLIER  Jefferson City Health and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  283 W Broadway Blvd Jefferson City, TN 37760	

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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policies, medical record review, manufacturer recommendations for administration of morphine extended release capsules and tablets, the facility's investigation, including witness statements, emergency medical services (EMS) records, police reports, hospital records and interviews, the facility failed to prevent significant medication errors for 1 resident (Resident #6) of 13 sampled residents. The facility failure occurred on 5/2/2024 when a staff nurse, Licensed Practical Nurse (LPN B) administered the wrong medications to the wrong patient, which included long-acting Morphine Sulfate (a potent opioid narcotic) 30 milligrams (mg) dose, extended release formula, Trazadone (an antidepressant) 200 mg dose, and Ativan 1 mg dose (a benzodiazepine, anxiolytic medication) in crushed form to Resident #6, not prescribed to Resident #6 in error. The error resulted in onset of mental status changes (severe sedation), which required emergency medical services (EMS) intervention and resulted in acute hospitalization of Resident #6, for emergent treatment of narcotic overdose. The facility census at the time of the incident was 142.</p> <p>The facility was cited at F 760 Scope/Severity G (Harm). The facility was cited as past non-compliance. No additional corrective actions are required.</p> <p>The findings include:</p> <p>Review of the facility policy, Medication Administration. revised 1/17/2023, revealed .Identify resident by photo in the MAR (medication administration record) .Compare medication source with MAR to verify resident name, medication name, form, dose, route and time of administration .Administer medication as ordered in accordance with manufacturer specifications .Correct any discrepancies and report to nurse manager .</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 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy, Medication Errors, revised 1/24/2024, revealed .It is the policy of this facility to provide protection for the health, welfare and rights of each resident by ensuring .services .free of significant medication errors .Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescribers order .or accepted professional standards and principals which apply to professionals providing services .The facility will consider factors indicating errors including but not limited to .Incorrect dose, route of administration, dosage, form, time of administration .incorrect medication .crushing do not crush medications .Medication not administered in accordance with professional standards and principals .To prevent medication errors and ensure safe administration, nurses should verify .right resident, right medication, right dose, right route and right time of administration . Adverse drug reactions and significant errors will be reported to the prescriber, director of nursing and pharmacy .These events will be reviewed as part of the facility QAPI (Quality Assurance Performance Improvement Committee</p> <p>Medical record review revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including Vascular Dementia, Atrial Fibrillation, Dysphagia, Acute Kidney Failure, Urinary Tract Infection, Sepsis, Cognitive Communication Deficits and Hypotension.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #6 scored 8 on the brief interview of mental status (BIMS) indicating severe cognitive impairment. Review revealed Resident #6 required assistance of one person for activities of daily living.</p> <p>Review of manufacturer's instructions for safe administration of Extended Release Morphine formulations posted online at the United States Food and Drug Administration (FDA) database, www.FDA.Gov/drugs, revealed a black box warning which read .instruct patients to swallow .whole to avoid exposure to potentially fatal dose of morphine .Instruct patients not to cut, break, chew, crush or dissolve the pellets .capsules to avoid the release and absorption of potentially fatal dose of morphine .Dosage Forms and Strengths . Extended Release Capsules .10 mg, 20 mg, 30 mg, 40 mg, 50 mg, 60 mg, 80 mg, 100 mg, 200 mg . Accidental Ingestion .Accidental Ingestion of even one dose .can result in fatal overdose .instruct patients unable to swallow .capsules whole, to sprinkle the capsule contents on applesauce and swallow .crushing, chewing or dissolving the pellets .capsules will result in uncontrolled delivery of morphine and can lead to overdose .</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's investigation and witness statements dated 5/2-3/2024, revealed on the evening of 5/2/2024 during the nighttime medication pass, between 7:30 PM and 8:30 PM, LPN B pulled medications from the medication cart which were prescribed to another resident, (complaint survey identified as Resident #5, a hospice patient diagnosed with end-stage metastatic Lung Cancer who lived in the room next door to Resident #6) in preparation for administration. After preparing the drugs and placing them in an administration cup in crushed form, LPN B then responded to the call light which had been activated by Resident #6. LPN B mistakenly administered Resident #5's medication to Resident #6. LPN B returned to the medication cart to document medication administration to Resident #6, realized the error when she viewed her computer screen and recognized Resident #5's medication had been pulled from the cart, crushed and given to Resident #6 by mistake. LPN B immediately notified the nursing supervisor (Registered Nurse, RN A) of the error and drugs/dosages given in error. RN A then immediately notified the on-duty house supervisor and the Director of Nursing (DON) and the attending Nurse Practitioner (NP) of the error. The NP issued instructions/verbal orders to monitor Resident #6 every 15 minutes and if signs or symptoms of overdose were detected or any changes in status occurred for Resident #6, administer intranasal Narcan (a narcotic antagonist which reverses side effects of opioids) and transfer Resident #6 to the local hospital. Continued review of the facility's investigation and witness statements revealed around 30 minutes after the medication error occurred, Resident #6 exhibited signs of overdose, was found slumped in her wheelchair unresponsive to sternal rubs or verbal stimuli. Facility staff transferred Resident #6 to the bed, as others sought Narcan for administration. The facility attempted to access Narcan for administration, discovered no intranasal supplies were available and supplies of injectable Narcan, stored in the facility's secured automated drug storage device that dispenses medications, were inaccessible because the recently installed device failed to recognize the biometric identifier (fingerprint) of the authorized users on duty that evening to allow immediate access to the injectable drug. The facility then immediately called 911 and advised EMS of the situation and drug overdose.</p> <p>Review of the EMS run sheet dated 5/2/2024, showed the facility dialed 911 at 8:43 PM. An ambulance was dispatched to the facility at 8:45 PM and arrived to the facility at 8:48 PM. EMS began treating Resident #6 at 8:49 PM, began transport and arrived at the emergency department (ED) at 9:06 PM. Continued review of the EMS run sheet revealed .Dispatched to (facility) .for report of drug overdose .Arrived on scene to find 92 YO (year old) female unresponsive, laying semi-Fowler (head of bed elevated) with slow respirations and radial pulse .pinpoint pupils, staff on scene advised that female was given wrong medication .(200 mg Trazadone, 1 mg of Ativan and 30 mg of Morphine) at 2000 hours (8:00 PM) .Patient was then given 2 mg of Narcan via nasal .female was then transferred to cot .placed in .semi-Fowlers position .Oxygen was then applied at 2/lpm (2 liters per minute) by nasal cannula .4 lead (electrocardiogram) showed female to have A-Fib (atrial fibrillation) with known history .IV (intravenous line) was then established .normal saline was then started at bolus rate .female was now starting to become more alert and was able to open her eyes and trying to speak .Female was then transported non-emergent to (hospital) due to being closest facility .At destination report was given to receiving nurse .</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the police report created 5/2/2014 at 10:21 PM revealed THE FOLLOWING IS A SUMMARY NOT VERBATIM OR AN ENTIRETY OF MY ACTIONS AND OBSERVATIONS [all caps] .On 5/2/2024 at 20:43 [8:43 PM] I .received a call at [facility] for an overdose .Jefferson County EMS and [NAME] City Fire Department responded to the scene as well .Upon arriving at scene, we were met at the door by nursing home staff who took us back to where the patient was. Nursing home staff was present in the room whenever I arrived at the room .Myself, Sgt (Sergeant) .and Ofc (officer) were all on scene . Continued review revealed .Jefferson County EMS .made contact with the patient [Resident #6] who had been administered [morphine .Lorazepam .trazadone crushed up] by mouth by LPN [LPN B] .[LPN B] was administering medications on this hall as part of her normal routine. [LPN B] was read her [NAME] Rights and was interviewed about the incident .</p> <p>Review of a police report dated 5/6/2024, showed detective notes revealed .Met with facility administrator and several staff members along with nurse on duty and [NP] was advised [LPN B] does not have any disciplinary actions, counseling or negative entries in her personnel file .Based on what was reported by several staff members .[LPN B] immediately notified 3 other nurses/coworkers as soon as she realized the wrong medications had been administered .Based on actions by the nursing staff, including [LPN B] it was determined no neglect or criminal intent or activity occurred This case will be closed as unfounded .I did report the incident to the (State Agency) .They were advised of the results of the investigation as well .</p> <p>Review of hospital records dated 5/2/2024, revealed Resident #6 was evaluated by the physician and underwent extensive workups in response to the incident. The physician documented Chief Complaint . Patient is resident at (facility) .Patient was given wrong medication by staff .received Morphine 30mg, Ativan 1mg, Trazadone 200mg at 8:00 PM .92 Y/O with past medical history of .who comes to us from .after receiving medication intended for another patient .She unfortunately became sedated and unresponsive . have been given Narcan en route with EMS .the drug screen is positive for opiates .patient was placed on Narcan drip in the emergency room .Because of these acute findings, hospital services was contacted for admission .</p> <p>Continued review of the physician note revealed HR 89 monitored, BP 133/78, SPO2 100% General: well appearing in no acute distress .Neurological: withdraws from stimulation, facial grimaces when attempting to check for pupillary responses .Psychiatric: sedated .</p> <p>Continued review of the hospital record showed Resident #6 was admitted to the intensive care unit (ICU) with admitting diagnoses including Drug Overdose, Altered Mental Status, Acute Cystitis without Hematuria, Acute Kidney Injury, Paroxysmal Atrial Fibrillation (chronic condition) Gastroesophageal Reflux Disease (chronic condition) and Hyperglycemia, for continued monitoring and was stabilized. Resident #6 was discharged back to the facility for continued care on 5/4/2024.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During telephone interview on 6/5/2025 at 7:17 PM, LPN B recounted the incident in detail. LPN B reported she pulled medications for Resident #5 from the medication cart crushed them, placed them in pill container, then noticed the call light in Resident #6's room activated and heard Resident #6 and her roommate calling out loudly. LPN B reported she carried Resident #5's medications with her to the room to avoid leaving them exposed on the cart. LPN B reported on arrival to Resident #6's room she calmed both residents who were upset with a malfunctioning television remote control, reset the television for Resident #6, then due to the distractions, forgot the medications in her hand weren't those prescribed for Resident #6, and administered them in applesauce to Resident #6 and left the room to return to the medication cart. LPN B reported both Resident #5 and #6 received crushed medications per physician orders and the rooms were beside each other on the unit, and she traditionally gave both residents their medications in sequence nightly. LPN B reported when she returned to her cart to sign off on the administration she realized her error at once when she observed she had Resident #5's photograph, medication administration record and narcotic reconciliation log atop the cart and those medications had been pulled from Resident #5's stocks. LPN B reported she immediately notified her supervisor of the error and in short order notified the prescribing clinician, (NP) who advised to monitor Resident #6 every 15 minutes, administer Narcan if signs of overdose or sedation arose, and then transfer Resident #6 to hospital at once. LPN B reported by that time multiple staff nurses on duty from other wings which included 2 Registered Nurses came to the unit, and assisted the unit manager in monitoring of Resident #6, counting medications on the cart for both residents to verify the error and confirm exactly what was given by mistake. LPN B reported initial checks of Resident #6 showed her vital signs stable and she remained alert. But on the second 15-minute check Resident #6 was found slumped over in the wheelchair and unresponsive by other staff. LPN B reported though she could not recall precise vital signs readings she noted Resident #6's blood pressure had dropped from the prior assessment and stated .it really hit her fast . in reference to the onset of symptoms of overdose. LPN B reported the facility immediately attempted to give Narcan with the onset of symptoms in Resident #6. LPN B reported neither she or her colleagues could locate Narcan on the medication cart or unit crash cart (a specialty cart used for emergency responses) and another staff nurse (LPN D) rapidly searched other carts in the facility for intranasal Narcan, while others she couldn't recall, discovered the Narcan stocked in the facility's [name of secure drug system] was of an injectable formulation, and not readily accessible at which time they called 911. LPN B recounted her conversations with police at the facility. Interview revealed LPN B acknowledged she committed the medication error as documented in the facility investigation and stated the error was both accidental and unintentional.</p> <p>During interview on 6/5/2025 at 7:58 PM, LPN D recalled the incident. LPN D reported LPN B informed her of the medication error immediately when it was identified and asked her for help.</p> <p>During interview on 6/9/2025 at 1:40 PM the DON confirmed the facility identified LPN B's serious medication error during initial investigation of the incident, at the time it occurred, then immediately formulated a corrective action plan which was monitored by the facility Quality Assurance Committee (QA) to prevent recurrences, in response to the incident.</p> <p>During interview on 6/9/2025 at 9:25 PM RN A, (who was the unit charge nurse on the night of the incident) reported the incident occurred sometime between 8:00 and 8:30 PM on 5/2/2024. RN A reported EMS arrived at the scene in less than 5 minutes once summoned. (This was consistent with the EMS run sheet data).</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 6/10/2025 at 11:00 AM the NP reported on the night of the incident as she was leaving the building sometime around 8:45 PM, (didn't recall precise time) she was informed of the medication error by staff. The NP reported at the time she was notified over the overdose, she herself was leaving the facility due to a family emergency and ordered Resident #6 to be given Narcan if any signs of sedation or decline arose and to immediately transfer the resident to a hospital should changes occur. The NP reported she was summoned back to the facility by police and arrived there after Resident #6 was taken to the hospital and she was then interviewed about the situation. The NP confirmed long-acting formulations of Morphine were not intended to be crushed for administration. The NP reported she was informed of Resident #6's transfer to the hospital by telephone when it occurred.</p> <p>In response to the incident, the facility implemented corrective actions. The facility's corrective actions were validated onsite between 6/5/2025 and 6/10/2025 during the onsite survey. The facility's corrective actions are summarized as follows:</p> <ol style="list-style-type: none"> <li>1.  On 5/2/2024 Resident #6 was transferred to the hospital for emergent care. An onsite investigation of the incident was initiated by the house supervisor with witness statements obtained.</li> <li>2.  On 5/2/2024 a brief ad hoc Quality Assurance (QA) review of the incident was held with members of the facility nursing leadership and administrator as the investigation was underway after law enforcement left the facility. An analysis of the initial investigation findings of the incident was discussed between Administration and Nursing Leadership. Initial responses to the incident and plans to re-educate all licensed nursing staff on relevant policies and procedures including the medication administration policy and facility policies related to safe drug administration procedures was formulated. Staff education began on the night of 5/2/2024 with expectations no staff would be allowed to work shifts after 5/4/2024 until all required medication re-training and competency assessments were completed. The remedial training materials utilized in response to the incident and training plan/competency testing was also added to the facility new hire orientation training program to augment current materials in use. All new hires were required to complete the training plan.</li> <li>3.  On the morning of 5/3/2024 a second ad hoc QA meeting was held which included all department heads, members of nursing leadership, facility administration, medical staff, pharmacy and the medical director in attendance. Additional responses to the incident were planned.</li> <li>4.  On the morning of 5/3/2024 the facility obtained Narcan formulated for intra-nasal administration from multiple local pharmacies and added it to every medication cart and crash cart in the facility as a stock medication, with tracking to ensure supplies were maintained in accordance with acceptable standards and expiration dates. Intra nasally administered Narcan was also obtained from the contracted pharmacy service and added to the Pyxis system to augment supplies of injectable Narcan already on hand.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>5.</p> <p>On 5/3/2024 the facility DON examined the medication administration policy and procedures with no negative findings or changes needed identified.</p> <p>6.</p> <p>On 5/3/2024 Medication Administration Record (MAR) audits and interviews of all current residents with BIMS scores of 8 or higher for medication accuracy were initiated with no additional negative findings or other at-risk residents identified. The audits and interviews were completed by 5/5/2024. MAR audits for all residents with BIMS scores less than 7 were also performed with no negative findings also completed by 5/5/2024 by the DON and Staff Education Coordinator.</p> <p>7.</p> <p>On 5/2/2024 Mandatory staff re-education for all licensed nurses was performed by the DON and designees which included the staff educator which included teaching on the 5 rights of medication administration as outlined in the facility policy and procedures, medication error policy, and procedures for medication administration for all medication types which included oral, nasal, topical, intravenous, parenteral, and injectable medication formulations. Re-training also included safe use of medical devices and glucometers. All staff were required to sign attestations training was completed and the facility policies acknowledged. All staff not on duty for vacations etc. were required to complete training prior to resumption of shifts. This was completed on 5/4/2024.</p> <p>8.</p> <p>Observations of medication passes by the DON or designee to assess for competency for all on duty staff nurses began on 5/3/2024 and was completed by the last shift on 5/4/2024.</p> <p>9.</p> <p>Individualized re-training and counseling was provided to LPN B on 5/4/2024 and observations of LPN B for medication administration competency were completed.</p> <p>10.</p> <p>On 5/6/2024 the facility initiated follow up observations of medication administration and additional competency evaluations for 5 nurses per week for a minimum of 5 resident medication passes for 4 weeks then continued assessments of 3 nurses and 3 resident medication passes weekly for 4 weeks, then 1 nurse and 1 resident medication pass weekly for 2 weeks. Documentation of the medication competency follow up observations was maintained in facility logs which were reviewed by the surveyor onsite. Observations of the logs showed the facility monitored competencies across all shifts. These audits were completed by 7/12/2024 with no new concerns identified.</p> <p>11.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility held additional QA meetings in which all findings related to the facility interventions and monitoring regimen were reviewed by the QA committee. Additional QA of the incident and findings related to the mitigation plan put into place were reviewed on 5/21/2024, 6/18/2024, 7/30/2024, and 8/27/2024. The facility QA committee ceased active QA monitoring of the remediation plan on 8/28/2024. This was verified by review of the QA sign in sheets and interviews.</p> <p>Observation of medication passes on 6/5/2025 on the day shift were conducted. Medication pass observations on the evening shift was completed on 6/9/2025. No medication errors or deficient practices were observed. Brief interviews of nursing staff were conducted on all shifts throughout the investigation and included questions on the facility medication administration policy, med error reporting policy, narcotics policy and protocols for use of Narcan, use of the Pyxis system, and observations of the Pyxis system in operation. Observations of the Pyxis system showed it was operational, but occasionally users had to wipe the finger touch screen with a clean cloth to allow the system to rapidly identify fingerprints. Observations of the medication carts and crash carts showed Narcan for nasal administration was readily available on all carts observed. Review of medication administration competency logs, cross referenced against the current employee log, which revealed all employees present at the time of the incident who remained employed at the facility, had received retraining as reported and remedial training LPN B reported she received in interview had been documented as completed. Personnel files were reviewed for 3 licensed nurses which included one person hired after the incident and verified medication training as outlined in the corrective actions had been incorporated into the new hire competency check list contained in the file. LPN B's personnel file was reviewed as well as her current licensure status. LPN B's personnel file showed prior to 5/2/2024, there were no documented performance or disciplinary actions as reported to law enforcement. It was notable at the time of the incident; LPN B had been licensed as a nurse for around 6 months (license issued 10/11/2023) and had been employed at the facility since March 2024. LPN B separated employment from the facility to seek other employment around 2 months after the incident and left in good standing. An online check of the Tennessee Board of Nursing Licensure Verification Page showed LPN B remained licensed in good standing with the board, with no pending or prior administrative actions or orders. Review of the personnel file also showed LPN B had graduated from an accredited LPN education program. Review of the facility incident logs showed no recurrent serious medication errors documented. After May 2024. Review of the grievance logs showed no grievances filed related to medications or alleged medication errors.</p>		