STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445263	A. Building B. Wing	12/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tri State Health and Rehabilitation Center	600 Shawanee Rd Harrogate, TN 37752

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, electronic mail (email) communication review, facility documentation review, observation, and interviews the facility failed to protect residents' rights to be free from misappropriation of narcotic medications for 1 resident (Resident #17) of 19 residents reviewed for misappropriation.The facility was cited at F-602 as Past Non-Compliance.Non-compliance began on 11/10/2025 and ended on 11/21/2025. The findings include:Review of the facility's undated policy titled, Abuse: Prevention of and Prohibition Against, revealed .It is the policy of this Facility that each resident has the right to be free from .misappropriation of resident property .The Facility will provide oversight and monitoring to ensure that its staff, who are agents of the Facility, deliver care and services in a way that promotes and respects the rights of the residents to be [free] from .misappropriation of resident property . Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings .Review of the medical record revealed Resident #17 was admitted to the facility on [DATE] with diagnoses including Pain, Seizures, and Type 2 Diabetes Mellitus. Review of a comprehensive care plan revised 6/3/2025, revealed Resident #17 was .at risk for chronic pain r/t [related to] osteoarthritis [breakdown of joint tissue] .Review of the physician's orders for Resident #17 dated 7/21/2025, revealed .Hydrocodone-Acetaminophen [pain medication] Tablet 7.5-325 MG [milligrams] .Give 1 tablet by mouth two times a day for pain . Further review revealed there was not a PRN (as needed) order for Hydrocodone-Acetaminophen 7.5-325 mg. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #17 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.Review of a facility reported incident dated 11/19/2025, revealed .Licensed nurse [Registered Nurse- RN A] reported possible med [medication] error on 11/17/2025 to ADON [Assistant Director of Nursing]. Upon investigation of reported potential med errors potential narcotic diversion [when a nurse illegally takes or redirects prescribed medication for personal use instead of the intended patient] identified, and investigation initiated on 11/17/2025. Immediately the nurse [Licensed Practical Nurse-LPN C] was removed from the med [medication] cart pending investigation beginning 11/17/2025 .Review of an Individual Resident's Controlled Substance Record (narcotic sheet) for Resident #17 revealed LPN C signed out an additional Hydrocodone 7.5-325 Mg tablet for Resident #17 on 11/10/2025 at 12:30 PM and on 11/16/2025 at 12:00 PM. Review of an email communication from the Pharmacy Nurse Consultant to the facility Administrator and Director of Nursing (DON) dated 11/19/2025 at 2:43 PM, with subject .Narcotic cost . revealed a narcotic audit had been performed and revealed extra doses of Hydrocodone had been signed out for Resident #17 .around noon . on 11/10/2025 and 11/16/2025.Review of a medication administration record (MAR) for 11/2025 for Resident #17 revealed the resident received 1 tablet of Hydrocodone-Acetaminophen 7.5-325 mg twice a day as ordered at 8:00 AM and 8:00 PM. Continued review revealed no documentation to indicate Resident #17 had received additional doses of Hydrocodone on 11/10/2025 or 11/16/2025. Further review revealed Resident #17's documented pain score was 0 for day shift and 2 for night shift on 11/10/2025 and 11/16/2025 (0 indicated no pain and 10 indicated worst possible pain). Review of a 5-day follow-up investigation report dated 11/21/2025, revealed .[LPN C] admitted she signed out extra medication that was not ordered for the resident [Resident #17] and took for herself .During a telephone interview on 12/16/2025 at 6:32 PM, RN A stated .We [RN A and LPN C] counted [narcotic count] .I noticed a resident [Resident #17] had an extra Hydrocodone signed out on that shift .I figured it was just an accident .I knew something was going on . RN A notified the ADON of the incident. During an observation and interview with Resident #17 on 12/17/2025 at 8:35 AM, revealed the resident was alert, smiling, and talkative and showed no signs or symptoms of pain. Resident #17 stated he had received his pain medications and voiced no concerns regarding administration of pain medications.During a telephone interview on 12/17/2025 at 10:10 AM, Pharmacy Nurse Consultant A stated she performed narcotic sheet audits and confirmed LPN C had signed out 2 additional doses of narcotic medication for Resident #17. Pharmacy Nurse Consultant A stated the audit showed the resident had not missed regularly scheduled doses of pain medication.During an interview on 12/17/2025 at 11:39 AM, the Administrator stated RN A reported she felt there was a medication error for Resident #17 involving one of the day shift nurses (LPN C). The Administrator stated she and the ADON immediately went to the medication cart and pulled the narcotic sheets for Resident #17. The Administrator confirmed LPN C had