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. **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 (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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 signed out extra pain medication for Resident #17. The Administrator stated LPN C was suspended pending the results of the investigation. The Administrator stated she and the DON met with LPN C on Thursday (11/20/2025) and told LPN C it appeared she was taking extra doses of pain medication which had been signed out on the narcotic sheet. LPN C confirmed she had signed out extra pain medication. The Administrator further stated LPN C's employment was terminated on 11/26/2025. During a telephone interview on 12/17/2025 at 12:50 PM, LPN C confirmed she had signed out extra narcotic medications for Resident #17. LPN C stated the resident received all scheduled narcotic medications, but she had signed out extra doses. A plan of correction was developed from 11/17/2025-11/21/2025 to address the deficient practice identified. The corrective actions were verified on-site by the surveyor on 12/16/2025-12/17/2025 through interviews and review of facility documents. Local police department, Adult Protective Services, and local Ombudsman were notified of the alleged incident. The facility's Plan of Correction included the following:1.) LPN C was immediately removed from the facility and suspended pending results of the investigation. LPN C's employment was terminated on 11/26/2025.2.) Pharmacy Nurse Consultant did a full medication cart/narcotic sheet audit on LPN C's assigned areas on 11/18/2025. No resident harm was identified by record reviews and interviews. Facility was charged for all medications which were identified as diversion.3.) 25 Residents were interviewed from 11/17/2025-11/18/2025 with no major concerns related to medication administration, increased pain, or nurse communication. No residents voiced concern regarding pain medication administration. The few residents who stated their current medication was not strong enough were seen by the NP and medications were assessed.4.) 100% of licensed staff were educated regarding misappropriation, signs of drug diversion, examples of drug diversion, and how to report drug diversion from 11/18/2025-11/21/2025. 5.) Beginning 11/25/2025 the nurse manager or Pharmacy Nurse Consultant will review all narcotic logs weekly x (times) 4 weeks to ensure no discrepancy. Any discrepancy will be reviewed immediately and reported to the DON.6.) Completed narcotic sheets will be given to the DON to audit monthly x 3 months. Results will be submitted to monthly Quality Assurance and Performance Improvement (QAPI) x 3 months. The process will be reviewed and continued as needed.7.) Root Cause Analysis performed with the following areas of potential identified: Shift to shift narcotic count and removal of discontinued medications from medication carts in a timely manner.8.) Nurse narcotic sheet count to nurse narcotic card count was evaluated with new procedure initiated on 11/21/2025. The new procedure included the off going nurse will count the medications and oncoming nurse will count and review the narcotic log sheets for accuracy. Area added to narcotic log for removal and addition of medication and narcotic sheets for total accuracy.9.) DON or designee will do random pharmacy delivery versus cart (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	audits 1x per week for 2 months and findings will be reported to QAPI. Random audits started on 11/24/2025.10.) The Administrator, DON, and Governing Body representative discussed the event, action plan, and interventions during an Ad Hoc (unplanned) QAPI meeting on 11/20/2025. The corrective action plan was immediately implemented, and it was recommended to continue for at least 3 months. QAPI committee will provide additional recommendations as necessary. Reported concerns will have interventions developed and appropriate actions taken by the Administrator in conjunction with the QAPI Committee. When current interventions are not producing the desired outcome or resolution to prior issues, the Administrator, in conjunction with the QAPI committee will provide additional recommendations and help develop alternate interventions until compliance is achieved and sustained. The facility Governing Board will be informed of any issues that may require additional oversight or guidance. A member of the Governing Body will review QAPI meeting minutes at least quarterly.Surveyor verified the following onsite:1.) Reviewed and validated onsite: Pharmacy Nurse Consultant completed a narcotic review for residents on the medication carts managed by LPN C. Verified the facility was charged for the diverted medication.2.) Reviewed and validated onsite: Interviews conducted on 11/18/2025 with residents with BIMS 10 or greater with no concerns.3.) Reviewed and validated onsite: Education related to narcotic diversion, recognizing and reporting diversion with sign in sheets for all licensed staff.4.) Reviewed and validated onsite: Audits for narcotic logs and narcotic sheet audits were performed as noted in the plan of correction.5.) Reviewed and validated onsite: New process for shift to shift narcotic counts was implemented on 11/21/2025.6.) Reviewed and validated onsite: The alleged misappropriation of narcotic medication was during an Ad Hoc QAPI meeting on 11/20/2025.Multiple interviews with licensed staff during the survey 12/15/2025 through 12/17/2025, staff verified through interviews they had received education on misappropriation, signs of drug diversion, examples of drug diversion, and how to report suspected drug diversion. Staff were knowledgeable of the new process for shift to shift narcotic counts and were knowledgeable about the facility's policies related to drug diversion and misappropriation.The deficient practice was cited as past non-compliance for F-602 and the facility is not required to submit a plan of correction.Non-Compliance began on 11/10/2025 and ended on 11/21/2025.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interviews, the facility failed to follow a Physician's order for 1 resident (Resident #9) of 19 residents reviewed for medication administration.The findings include:Review of the facility's policy, titled Administering Medications undated revealed, .Medications are administered in a safe and timely manner, and as prescribed .Medications are administered in accordance with prescriber orders .Medications are administered as ordered .Right Patient .Right Med .Review of the medical record revealed Resident #9 was admitted to the facility on [DATE], with diagnoses including Depression, Anxiety Disorder, Brief Psychotic Disorder, and Cognitive Communication Deficit.Review of the annual Minimum Data Set assessment dated [DATE], revealed Resident #9 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment indicating the resident was cognitively intact.During an observation on 12/16/2025 at 9:29 AM, revealed a clear medication cup on the bedside table with 4 unknown pills on Resident #9's bedside table. During an interview on 12/16/2025 at 3:22 PM, Licensed Practical Nurse (LPN) B identified the medications left on the bedside table as (1) Meclizine (medication for dizziness) over the counter (OTC) and (1) Vitamin B-12 OTC. LPN B confirmed she administered the medications without a physician's order. Review of an Order Summary Report for Resident #9 dated 12/2025, revealed no order for meclizine (medication for dizziness) and vitamin B-12. During an interview on 12/16/2025 at 3:37 PM, the Administrator and Director of Nursing confirmed it was the expectation medications were to be administered to the resident as ordered by the physician. During an interview on 12/17/2025 at 10:00 AM, Nurse Practitioner (NP) A stated, .I was notified of the additional medications she was given, she did not have an order for those. I do not believe there would be a negative outcome from receiving Meclizine and B12. My expectation is for the nurse to follow the medication rights before giving medications . Further interview revealed Resident #9 was assessed on 12/16/2025 after notification of the medication error.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure the safety of 1 resident (Resident #9) of 19 residents reviewed for accidents. The findings include:Review of the facility policy titled, Administering Medications undated revealed .Medications are administered in a safe and timely manner .The nurse providing/administering the medications will verify consumption compliance .Review of the medical record revealed Resident #9 was admitted to the facility on [DATE], with diagnoses including Depression, Anxiety Disorder, Brief Psychotic Disorder, and Cognitive Communication Deficit.Review of the annual Minimum Data Set assessment dated [DATE], revealed Resident #9 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.During an observation on 12/16/2025 at 9:29 AM, revealed a clear medication cup with 4 pills on Resident #9's bedside table. During an interview on 12/16/2025 at 9:39 AM, Licensed Practical Nurse (LPN) B stated .She [Resident #9] takes them one at a time. That was my fault. I go in with her meds, and she takes them in front of me. When I was there, I put them down, I didn't see her take them all. That was my mistake .During an interview on 12/16/2025 at 3:37 PM, The Administrator and Director of Nursing (DON) stated it is the expectation that medications are to be administered and not left at the bedside unattended.

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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** Based on facility policy review, review of manufacturer guidelines, medical record review, observation, and interview the facility failed to store insulin pens appropriately for 3 residents (Resident #15, #25 and #78) on 1 medication cart of 3 medication carts observed for medication storage.The findings include:Review of the facility policy titled, Administering Medications, undated, revealed .Medications are administered in a safe and timely manner .When opening .the date opened is recorded on the container .Review of manufacturer guidelines, dated 7/2022, revealed .TRESIBA [medication used to treat Diabetes] .(insulin degludec) .should be thrown away after 56 days, even if it still has insulin left in it .Review of manufacturer guidelines, dated 5/2025, revealed .Lantus [medication used to treat Diabetes] Only use your pen for up to 28 days after its first use .Throw away the Lantus .pen you are using after 28 days .Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes, Generalized Anxiety Disorder, and Dementia.Review of the physician's orders for Resident #15 dated 12/15/2025, revealed .Tresiba .Subcutaneous [injection given under the skin] .100 UNIT/ML [milliliter] .(Insulin Degludec) .Inject 50 unit subcutaneously .one time a day .related to TYPE 2 DIABETES .Review of the medical record revealed Resident #25 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes, Obesity, and Anxiety Disorder.Review of the physician's orders for Resident #25 dated 12/8/2025, revealed .Lantus .Subcutaneous .Pen-injector .100 UNIT/ML .Inject .40 unit subcutaneously .one time a day . for DM [Diabetes Mellitus] .Review of the medical record revealed Resident #78 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes, Hypertension, and Congestive Heart Failure.Review of the physician's orders for Resident #78 dated 5/29/2025, revealed .Tresiba .Subcutaneous .Pen-Injector 200/UNIT/ML .(Insulin Degludec) .Inject 28 unit subcutaneously two times a day for diabetes .During an observation of the medication cart for the 200/400 hallway on 12/16/2025 at 8:15 AM, revealed 2 Degledec Insulin 100 UNIT/ML Flexpens at room temperature for Resident #15 and Resident #78 and the insulin was undated when opened. Further observation revealed an opened Lantus Insulin 100 UNIT/ML Flexpen at room temperature for Resident #25 and the insulin was undated when opened.During an interview on 12/16/2025 at 8:17 AM, Licensed Practical Nurse A confirmed medications were not stored properly for Residents #15, #25, and #78.During an interview on 12/17/2025 at 1:45 PM, the Director of Nursing confirmed medications were not stored properly for Residents #15, #25, and #78.