STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445314	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Morristown	501 West Economy Road Morristown, TN 37814

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35460 Based on facility policy review, medical record review, facility reported incident review, interviews, employee record review, and facility plan of correction review, revealed the facility failed to ensure controlled medications were accurately reconconciled for 1 (Resident #1) of 6 residents reviewed for controlled and scheduled medications. The findings include: Review of the pharmacy policy titled Storage and Expiration Dating of Medication, Biological, dated [DATE] revealed .Facility should ensure .controlled substances are only accessible to licensed nursing, Pharmacy, and medical personnel designated by the facility .Controlled Substances stored in the refrigerator must be in a separate container and double locked . Review of the policy Management of Controlled Substances, dated [DATE] revealed .The facility will maintain a system to account for controlled medications' receipt and disposition in sufficient detail to enable an accurate reconciliation, and that the facility conduct a periodic reconciliation. This system includes but is not limited to a record of receipt of all controlled medication with sufficient detail to allow reconciliation .specifying the name and strength of the medication, the quantity and date received, and the resident's name . Review of the facility policy titled Reporting and Investigating an Allegation of or Suspected Drug Diversion, dated [DATE] revealed .the facility in coordination with the pharmacist provides for : (1) A system of medication records that enables periodic accurate reconciliation and accounting for all controlled medications (2) Prompt identification of loss or potential diversion of controlled medications (3) Determination of the extent of loss or potential diversion of controlled medications 'Diversion of medications' is the transfer of a controlled substance or other medication from a lawful to unlawful channel of distribution or use, as adapted from the Uniform Controlled Substances Act . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Hereditary Hemochromatosis (a genetic disease in which too much iron builds up in the body and can cause severe liver disease and other health problems), Failure to Thrive, Functional Quadriplegia, Cirrhosis of the Liver, Hepatic Encephalopathy, Psychotic Disorder with Delusions due to known physiological conditions and Anxiety. (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Order Recapitulation [Recap] Report for Resident #1 dated [DATE], revealed the resident was monitored for behaviors related to a diagnosis of Anxiety such as: anxiousness, agitation, physically combative with care, verbally aggressive at times, and refusal of care. Review of the medical record and review of the Order Recap Report for Resident #1 revealed an order dated [DATE], ABHR [a cream with Ativan [anti-anxiety medication], Benadryl [antihistamine with sedative effects], Haldol [antipsychotic medication], Reglan] Ativan 1 milligram (mg), Benadryl 25 mg, Haldol 1mg, Reglan 10 mg, apply 1 syringe to inner wrist topically in the evening for agitation related to psychotic disorder with delusions due to known physiological condition. Continued review of the medical record revealed Resident #1 was under hospice services. Review of a facility reported investigation dated [DATE], revealed the spouse of Licensed Practical Nurse (LPN) A called the Director of Nursing (DON) and requested she meet him in the parking lot of the facility. The DON and Assistant Director of Nursing (ADON) went to the parking lot where the spouse of LPN A was waiting with an on duty police officer. The spouse presented the DON and the ADON with a plastic bin that contained 30 individual dose syringes of the ABHR cream labeled with Resident #1's name. During an interview on [DATE] at 8:00 AM and review of LPN A's employee record, revealed the last day the LPN worked at the facility was [DATE]. The LPN was on a medical leave of absence which started on [DATE]. On [DATE] the LPN was arrested for a domestic situation, was placed on suspension by the facility, and was terminated on [DATE]. The DON further stated she had questioned LPN A about the medications her spouse brought to the facility and the LPN stated to the DON, she had obtained the medications for Resident #1 out of the lock box in the refrigerator and had put in her pocket. During an interview on [DATE] at 10:15 AM, the DON stated the facility would not have known Resident #1's medications had been diverted if LPN A's husband had not returned the medications to the facility. Continued interview and review of the photos of syringes of the ABHR medication revealed the medications were unused. Further interview, review of the photos, and documentation of the medication audit completed by the DON and the Pharmacist determined each batch of the compounded medications (pharmacy combines the medications and puts into a gel form) was identified with Resident #1's name, the batch number, and the date it was received by the facility. The MARs for Resident #1 were reviewed and were documented as administered. During an interview on [DATE] at 10:30 AM, the Administrator confirmed the facility had re-imbursed the hospice agency for Resident #1's diverted ABHR medications. During a telephone interview on [DATE] at 10:00 AM, LPN A stated she just put the ABHR medication in her pocket to be administered and had accidently taken the medication home. LPN A further stated she should have returned the medication to the facility. Review of the facility plan of corrections for Medication Management dated [DATE] with a completion date of [DATE], were validated on-site by the surveyor on [DATE]-[DATE] through interviews and review of facility documents. The following corrective actions were implemented: [DATE] 1. Notification of the physician, responsible party, and local and state agencies. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Initiated an inventory of all resident's medications with a MAR (medication administration) for each resident's current orders. 3. Initiated an investigation interview for drug diversion questionnaire with all licensed nurses and began re-education on the following policies: Management of Controlled Substances Disposal/Destruction of Expired or Discontinued Medications, Reporting and Investigating an Allegation of or Suspected Drug Diversion, Medication Administration Basics: Rights of Medication Administration, Change of Shift Counts, Discontinued and Destruction of Narcotics, Managing Controlled Substances, Abuse Identification of Types, Protection of Residents: Reducing the threat of Abuse and Neglect, Resident Rights, Abuse Reporting and Response, No Crime Suspected, Abuse, Neglect, Exploitation (ANE) Allegation Investigation Checklist, Abuse Conducting Investigation, Elder Justice Act Fact Sheet, Abuse Coordination with the QAPI [Quality Assurance Performance Improvement] Committee, Person Centered Care Planning, Changes in Resident's Condition, Behavior Health Management, and Customer Service . [DATE] 1. A Quality Assurance Performance Improvement (QAPI) meeting was held, with the Interdisciplinary Team and conducted a root cause analysis to determine what correctional actions needed to be taken. 2. The DON/ADON received reeducation on Controlled Substance Procedure Review Process, Work Tol, and Detailed Summary from the Regional Department of Clinical Services. 3. The Administrator reviewed all the Concern and Comment forms dated [DATE]-[DATE] for allegations of Abuse/Neglect/Misappropriation with no reported concerns identified. 4. Residents with a Brief Interview Mental Status (BIMS) assessment of 9 or greater (moderately cognitively impaired to cognitively intact) were interviewed related to the medication administration and treatment by the facility staff. Residents with a BIMS assessment of 8 or less had their medical record reviewed for any signs/symptoms documented that may have indicated they had not received their ordered medications. 5. LPN A was terminated. [DATE] 1. The DON/ADON/Designee will audit 2 random residents per medication cart with a controlled substance ordered to ensure the controlled substance procedure is followed. The audits were to be conducted 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then 1 time weekly for 4 weeks. Any disciplinary action needed will be conducted immediately. All audits with be reported to the QAPI committee meeting for 3 months. 2. The DON/ADON/Designee will conduct a 100% audit of all residents' medications and compare the medications accounted for, available, and match the (MAR) The audits were to be conducted weekly times 4 weeks, then bi-weekly times 4 weeks, and then monthly and reported to the QAPI committee for 3 months. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of LPN A's employee record and interview with the DON on [DATE] at 8:00 AM, revealed the last day the LPN worked at the facility was [DATE]. The LPN had been on a medical leave of absence which started on [DATE]. On [DATE] the LPN was arrested for a domestic situation and was placed on suspension. Continued interview confirmed LPN A was terminated by the facility on [DATE]. During further interview the DON stated she questioned LPN A about the medications, the LPN stated she had obtained the medication out of the lock box in the refrigerator, put in her pocket and then forgotten to administer the medication. During an observation of medication administration on [DATE] at 11:00 AM, Registered Nurse (RN) B administered controlled substances for 3 residents with no concerns identified. During an interview on [DATE] at 11:45 AM RN B confirmed she had received the re-education of the medication administration and was positive the medication reconciliation procedure was being followed. During an observation on [DATE] at 10:00 AM, with RN E confirmed the Resident #1's ABHR medication was stored in the locked medicine room, the refrigerator was locked and once opened there was an additional locked box which contained the correct number of doses of medication. During an interview on [DATE] at 10:15 AM, with the DON revealed the facility would not have known the medications had been diverted if LPN A's husband had not returned the medications to the facility. Continued interview and review of the photos of syringes of ABHR revealed they were unused. Further interview and review of the photos and documentation of the medication audit completed by the DON and Pharmacist determined each batch of the compounded (pharmacy combines the medications and puts into a gel form) medications was identified by Resident #1's name, the batch number, and the date it was received by the facility. The MARs for Resident #1 were reviewed and the medication was documented as having been administered. All staff were re-educated on obtaining controlled substances from the refrigerator and to not place any medications in a uniform/jacket pocket. The surveyor interviewed a total of 7 residents throughout the complaint survey conducted on [DATE]-[DATE] with no reported concerns with medication administration. During interviews with 9 facility licensed staff conducted throughout the complaint survey on [DATE]-[DATE] revealed they were not aware of any medication diversion or concerns with the reconciliation of controlled substances in the past and had recently received a lot of re-education on the process for medication administration, documentation, reconciliation of controlled substances. Review of the grievances from [DATE]-[DATE] revealed no unresolved care concerns. The deficient practice of failure to ensure controlled substances were not diverted and was cited as past noncompliance. The facility was not required to submit a plan of correction.