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	06/26/2024

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41291 Based on facility policy review, medical record review, observations, and interviews, the facility failed to maintain a safe homelike environment when water leaked under the baseboard into 1 room (room [ROOM NUMBER]) from 1 shower room (West Long Hallway Shower Room) of 3 shower rooms observed. The findings include: Review of the facility's policy titled, Resident Belongings and Home Like Environment, dated 6/12/2024, revealed .The facility will provide a safe, clean, comfortable, and homelike environment .It is the responsibility of all facility staff to create a homelike environment and promptly address any .needs . Review of the medical record revealed Resident #6 (who resided in room [ROOM NUMBER]) was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease and Atrial Fibrillation. During an observation and interview of Resident #6 in room [ROOM NUMBER] on 6/25/2024 at 8:50 AM, revealed several blankets rolled up, lying against the baseboard on the right-hand side wall upon entering the room. Resident #6 stated, .water leaks under the wall sometimes from the shower room and the staff put those [blankets] down to catch the water . Resident #6 further stated the blankets in the floor .don't bother me .I can't get out of bed .I wouldn't have known they [blankets] were there, if staff hadn't told me what they were doing . Continued interview with Resident #6 revealed the resident was unable to state how long the water leak had been happening, but stated, .it's not been that long .maybe a couple of weeks . During an interview on 6/25/2024 at 8:56 AM, Licensed Practical Nurse (LPN) J stated the shower room (West Long Hallway Shower Room) on the other side of the wall (room [ROOM NUMBER]) leaks when the showers are used. He further stated we (staff) noticed water in the floor every time the shower was in use; room [ROOM NUMBER] is the only room affected by the shower leaking under the wall. During interviews on 6/25/2024 at 9:06 AM, the Director of Housekeeping and Housekeeper K stated the shower room on the [NAME] Long Hallway had been leaking for a couple weeks. The Director of Housekeeping stated she thought a work order had been put in with maintenance. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews outside of room [ROOM NUMBER] on 6/25/2024 at 9:16 AM, the Administrator and the Maintenance Director stated the water started seeping under the baseboard in room [ROOM NUMBER] after the shower mixing valve had been replaced a couple of weeks ago. Both stated they were unaware the [NAME] Long Shower Room was being used; they thought the residents were still being taken to the other shower rooms on the New Wing. The Maintenance Director denied receiving maintenance requests about the [NAME] Long Hallway Shower Room and stated, .the shower did not leak before .this is new . The Maintenance Director stated the wall in the shower room could be repaired without having to move Resident #6 from room [ROOM NUMBER]. The Administrator and the Maintenance Director confirmed the water leaking under the baseboard in room [ROOM NUMBER] from the [NAME] Long Hallway Shower Room did not provide a safe homelike environment. During an interview on 6/25/2024 at 9:30 AM, Registered Nurse (RN) L stated the shower on the [NAME] Long Hallway was first used sometime between 6/7/2024-6/10/2024 by a hospice staff person providing a shower to a hospice resident. After the hospice staff person finished using the shower room (West Long Hallway Shower Room), it was reported there was water along the baseboard in room [ROOM NUMBER]. RN L stated she was unable to recall if a maintenance request had been put in or if maintenance was called on the telephone but did recall someone from maintenance came to the unit and looked at the water along the baseboard in room [ROOM NUMBER]. RN L was unable to state if anything had been done to fix the leak. During an interview and observation on 6/25/2024 at 9:47 AM, Certified Nursing Assistant (CNA) N stated she first used the shower room on the [NAME] Long Hallway on 6/21/2024. CNA N was unable to recall if hospice had used the shower that day. CNA N stated towards the end of the showers for the day is when she noticed water along the baseboard in room [ROOM NUMBER]; the shower room is adjacent to room [ROOM NUMBER]. CNA N stated the issue had been reported to the charge nurse. The [NAME] Long Hallway Shower Room had been used twice- once on 6/21/2024 and on 6/25/2024. CNA N further stated after the first shower today (6/25/2024) was when a small amount of water was noticed along the baseboard in room [ROOM NUMBER]; blankets were rolled up and placed on the floor near the baseboard to absorb the water to prevent anyone from falling; and had not been reported or a maintenance request form had not been completed. CNA N continued to provide a second shower after water had been found along the baseboard in room [ROOM NUMBER] from the [NAME] Long Hallway Shower Room. CNA N stated the rolled blankets along the baseboard in room [ROOM NUMBER] were the same blankets that had been placed after the first shower, when the water was noticed. An observation of the rolled blankets along the baseboard in room [ROOM NUMBER], revealed the edges of the rolled blankets were wet, but not soaked. CNA N stated, .the blankets have never been soaking wet .the water leaking under the baseboard has only been small amounts . During an interview on 6/25/2024 at 9:56 AM, the Director of Nursing (DON) stated effective immediately the [NAME] Long Hallway Shower Room was in non-working order and an Out of Order sign had been placed on the door (6/25/2024).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27405 Based on facility policy review, medical record review, facility investigation documentation review, police report review, and interview, the facility failed to protect the residents' right to be free from physical abuse from another resident for 1 resident (Resident #135) of 6 residents reviewed for abuse. On [DATE], Resident #136 struck Resident #135 in the face with her foot. The findings include: Review of the facility policy titled, Abuse Prevention, issued [DATE], revealed .It is the policy of this facility to prevent and prohibit all types of abuse . Review of the medical record revealed Resident #135 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Dementia, Type 2 Diabetes Mellitus, and Chronic Kidney Disease. Continued review revealed the resident expired in the facility on [DATE]. Review of a annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #135 scored an 0 on the Brief Interview for Mental Status (BIMS) assessment which indicated severe cognitive impairment. Review of a Nursing Progress Note for Resident #135 dated [DATE], revealed .resident is more aggressive and agitated by the voices he hears .spoke with residents nephew .gave an update .also informed him that we got an order to get a UA [urinalysis] .due to increased agitation .[nephew] concerns .[the resident] was on antipsychotic for a while .recently taken off, states that resident has been on for years and behaviors will get worse the longer he is off medication . Review of the comprehensive Care Plan for Resident #135 revised [DATE], revealed, .Focus: resident behavior problem r/t [related to] dx [diagnosis] of anxiety, psychosis .interventions q [every] 15 minute checks x [times] 24 hours .psyche [psychiatric] visit/follow up- GDR [gradual dose reduction] failed, restart medication .treatment for UTI [urinary tract infection] . Review of the medical record revealed Resident #136 was admitted to the facility on [DATE] with diagnosis including Dementia, Alzheimer's Disease, Muscle Weakness, and Insomnia. Continued review revealed the resident discharged to a hospice home on [DATE]. Review of a quarterly MDS assessment dated [DATE], revealed Resident #136 scored a 0 on the BIMS assessment which indicated severe cognitive impairment. Review of the Nursing Progress Note for Resident #136 dated [DATE], revealed .yelling after dinner this shift. Res [resident] attempts sliding out of chair. Will continue to monitor resident at nurse's station . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation dated [DATE], revealed .[Resident #136] .was up in her [NAME] [type of positioning chair] chair reclined back and when she scooted to the bottom and swung her foot out striking another resident .[Resident #135] on his face, while laughing .nurse intervened and took resident to her room .RP [responsible party] notified, ED [executive director], police .state survey agency .MD [medical doctor] .q [every] 15 minute checks initiated .dycem [non-skid/slip material] added to seat of [NAME] chair to prevent from scooting down in chair XXX,d+[DATE] psyche visit . Review of the comprehensive Care Plan for Resident #136 revised [DATE], revealed .resident to resident altercation due to dementia with behaviors .interventions q 15 minute checks x [times] 24 hours, psyche visit . dycem in seat of [NAME] chair . Review of a Police report investigation dated [DATE], revealed .on [DATE] officers received a call from . [name of facility] about 2 residents that got into an altercation .stated the suspect [Resident #136] was sitting at the nurse's station when the victim [Resident #135] rolled up to the nurse's station and asked for a snack. The suspect then proceeded to kick the victim in his face while he was in the wheelchair .there appeared to be no marks on [Resident #135] face .[Resident #135] was asleep upon arriving by his bedside .both have diminished mental capacity . Review of a Skin Assessment for Resident #135 completed on [DATE], revealed no injuries or new areas found. Review of a Psychiatric Nurse Practitioner (NP) note for Resident #135 dated [DATE], revealed .I am seeing this patient [Resident #135] as a follow-up. Facility staff report resident to resident altercation involving [Resident #135] this morning. Per facility staff the patient was ambulating in his wheelchair in the common space when he approached another resident. [Resident #136] .swung her leg into the air and struck [Resident #135] in the head. Facility intervened and implemented appropriate measures. Law enforcement was involved .[Resident #135] was not injured. On exam patient [Resident #135] is resting comfortably .he does not recall the events .he is not agitated .facility staff report increased restlessness and agitation .see note ,d+[DATE] [[DATE]] .at that time I recommended .GDR [gradual dose reduction] .symptoms seem to be worsened since the discontinuation of this agent. It will be restarted today . Review of a Psychiatric NP Note for Resident #136 dated [DATE] revealed .resident of long term care facility with past psychiatric history significant for Alzheimer's disease .staff report a resident to resident altercation involving .[Resident #136] this morning. Per facility staff report, another resident wheeled up to her .hit the other resident in the head. The 2 were separated in the facility staff implemented appropriate interventions . the patient has had poor sleep over the last several days .on exam .she is resting comfortably .she is confused. Her affect is flat .she does not recall the incident whatsoever .she is followed by hospice .no acute distress .she is currently being monitored on q [every] 15-minute checks .I have provided caregiver education and counseling regarding safety issues to the facility staff .daughter refuses medication changes . During an interview and medical record review on [DATE] at 9:15 AM, the Director of Nursing (DON) stated Residents #135 and #136 both had no prior resident to resident altercations denied any lasting effects with neither resident remembering the altercation. Continued interview and medical record review revealed the residents had no further resident to resident altercations while residents in the facility. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 9:24 AM, Licensed Practical Nurse (LPN) M stated she was at the nurse's desk when incident happened on [DATE], and she observed Resident #135 roll by Resident #136 in his wheelchair, and Resident #136 slid down in her [NAME] chair and kicked him (Resident #135). Continued interview revealed Resident #135 was not affected and continued to roll by Resident #136 not stopping. Interview revealed the residents were immediately separated with neither resident having any injury noted. During an interview on [DATE] at 2:22 PM, the Administrator and DON confirmed physical contact did take place between Resident #135 and Resident #136, when Resident #136 struck Resident #135, and neither resident sustained injuries.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35460 Based on review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, medical record review, and interview, the facility failed to complete a significant change assessment for 3 residents (Residents #15, #17, and #2) of 24 residents reviewed. The findings include: Review of CMS's RAI Version 3.0 Manual Chapter 2 dated 10/2023, revealed .Guidelines to Assist in Deciding If a Change Is Significant or Not .When a .Resident enrolls in a hospice program .must be within 14 days from the effective date of the hospice election . Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Diabetes Mellitus Type 2, and Weakness. Review of a Physician's Order dated 5/21/2024, revealed Resident #15 was admitted to hospice services. Review of a significant change in status Minimum Data Set (MDS) assessment dated [DATE], for Resident #15 revealed the MDS assessment was in progress and not been submitted for approval to CMS within the 14 day requirement. During an interview conducted on 6/26/2024 at 9:25 AM, with the MDS Coordinator A confirmed the significant change in status MDS had not been completed within the 14 day requirement. 41291 Review of the medical record revealed Resident #17 was admitted to the facility on [DATE] with diagnoses including Cirrhosis Of Liver, Atrial Fibrillation, Congestive Heart Failure, Psychotic Disorder with Delusions, and Hepatic Encephalopathy. Review of a Physician's Order for Resident #17 dated 1/24/2023, revealed .Hospice Services: admitted [DATE] [1/24/2023]with a diagnosis of Hepatic Failure . Review of an entry MDS assessment dated [DATE], revealed Resident #17 was readmitted to the facility. A significant change in status MDS was never completed to capture the new order for hospice services within 14 days. During an interview on 6/26/2024 at 10:10 AM, MDS Coordinator A confirmed Resident #17 was admitted to hospice services on 1/24/2023 and a significant change in status assessment had not been completed within the 14 days. 50216 (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Failure to Thrive, Dementia, and Repeated Falls. Review of the Physician's Order for Resident #2 dated 7/6/2023, revealed .has a terminal prognosis of Alzheimer's disease [Disease]. admitted to .Hospice 7/6/2023 . Review of the MDS assessments revealed a significant change in status was not completed within 14 days of the admission to hospice on 7/6/2023. During an interview on 6/26/2024 at 1:03 PM, the MDS Coordinator A stated a significant change was not completed within 14 days of Resident #2's admission to hospice on 7/6/2023.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50216 Based on review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, medical record review, and interview, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 3 residents (Resident #46, #2 and #17) related to the use of hospice, restraints and falls of 24 residents reviewed. The findings include: Review of the RAI Version 3.0 Manual, Chapter 3, dated 10/2023, revealed .Determine the number of falls that occurred since .prior assessment (OBRA or Scheduled PPS) and code the level of fall-related injury for each .Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions .Identify all physical restraints that were used at any time (day or night) during the 7-day look back period . Review of the medical record revealed Resident #46 was admitted to the facility on [DATE] with diagnoses including Hypertension, Alzheimer's Dementia, and Osteoarthritis. Review of a Physician's Order for Resident #46 dated 3/6/2024, revealed .Soft posey belt [a type of trunk restriant] to wheelchair - check every 30 minutes and release every 2 hours and as needed . Review of an annual MDS assessment for Resident #46 dated 4/1/2024, revealed restraint usage was not captured during the 7 day look back period. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Failure to Thrive, Dementia, and Repeated Falls. Review of a Physician's Order for Resident #2 dated 7/6/2023, revealed the resident was admitted to hospice services. Review of an annual MDS assessment for Resident #2 dated 8/15/2023, did not reveal the resident had received hospice services. Review of a Physician's Order for Resident #2 dated 10/23/2023, revealed the resident had an order for a lap buddy restraint [a type of trunk restraint]. Review of a quarterly MDS assessment for Resident #2 dated 11/13/2023, revealed restraint usage was not captured during the 7 day look back period. Review of a quarterly MDS assessment for Resident #2 dated 2/12/2024, revealed restraint usage was not captured during the 7 day look back period. Review of a quarterly MDS assessment for Resident #2 dated 5/8/2024, revealed restraint usage was not captured during the 7 day look back period. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/2024 at 1:03 PM, the MDS Coordinator A confirmed Resident #46's MDS assessment dated [DATE] had not captured restraint usage and was coded incorrectly. Further interview confirmed Resident #2's MDS assessments dated 8/15/2023, had not captured hospice services, and the quarterly MDS assessments dated 11/13/2023, 2/12/2024, and 5/8/2024, had not captured the usage of trunk restraints and were not coded accurately. 41291 Review of the medical record revealed Resident #17 was admitted to the facility on [DATE] with diagnoses including Cirrhosis Of Liver, Atrial Fibrillation, Congestive Heart Failure, Psychotic Disorder with Delusions, and Hepatic Encephalopathy. Review of a Physician's Order for Resident #17 dated 1/24/2023, revealed .Hospice Services: admitted [DATE] [1/24/2023] with a diagnosis of Hepatic Failure . Review of the facility's form titled, Incidents Follow-up & Recommendation Form for Resident #17 dated 4/4/2023, revealed the resident had fall with no injury. Review of the quarterly MDS assessment for Resident #17 dated 4/12/2023, revealed falls and hospice services had not been captured. Review of the facility's form titled, Incidents Follow-up & Recommendation Form for Resident #17 dated 6/23/2023, revealed the resident had fall with minor injury (skin tear). Review of the quarterly MDS assessment for Resident #17 dated 7/7/2023, revealed falls and hospice services had not been captured. Review of the annual MDS assessment for Resident #17 dated 10/4/2023, revealed the resident received hospice services. (The resident had been under hospice services since 1/24/2023, upon return from hospitalization , and was not captured on the 4/12/2023 or 7/1/2023 quarterly MDS assessments.) During an interview on 6/26/2024 at 10:10 AM, the MDS Coordinator A stated he was responsible for Resident #17's MDS assessments. MDS Coordinator A confirmed Resident #17 had been admitted to hospice services on 1/24/2023 and had falls on 4/4/2023 and 6/23/2023; the falls and hospice services had not been captured on the quarterly MDS assessments dated 4/12/2023 and 7/7/2023; and the quarterly assessment were inaccurate.