STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445377	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Erin	278 Rocky Hollow Road Erin, TN 37061

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 - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28913 Based on policy review, medical record review, facility document review, and interview, the facility failed to ensure residents' rights to be free from misappropriation of controlled narcotics for 7 of 9 (Resident #1, #2, #5, #6, #7, #8, and #9) sampled residents reviewed with orders for controlled narcotics. Resident #1 had a total of 48 tablets of Oxycodone 10 milligram (mg) missing. Resident #2 had a total of 61 tablets of Oxycodone 5 mg missing. Resident #5 had a total of 78 Hydrocodone 7.5 mg tablets missing. Resident #6 had a total of 28 tablets of Oxycodone 5 mg missing. Resident #7 had a total of 94 tablets of Oxycodone 10 mg missing. Resident #8 had a total of 144 tablets of Hydrocodone 5 mg missing. Resident #9 had a total of 56 tablets of Hydrocodone 5 mg missing. On [DATE] the facility discovered Resident #2's Controlled Drug Record sheet (a form for documentation of the ongoing number of narcotic medications in the medication cart) had been removed from the Controlled Substance Count sheet (a form for documentation of the number of Controlled Drug Record sheets) and could not be located. The facility's failure to ensure all residents were free of misappropriation abuse of resident property resulted in Immediate Jeopardy (IJ) for Residents #1, #2, #5, #6, #7, #8, and #9. The facility's failure to ensure the residents' rights to be free from misappropriation abuse of resident property (narcotic medications) resulted in Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, a serious injury, harm, impairment or death to a resident). The Interim Administrator, the Director of Nursing (DON), and the Regional Signature Care Coordinator (SCC) were notified of the Immediate Jeopardy for F-602 on [DATE] at 1:08 PM in the Conference Room. F-602 was cited at a scope and severity of K which is Substandard Quality of Care. A partial extended survey was conducted from [DATE] through [DATE]. The Immediate Jeopardy began [DATE], continued through [DATE], and was removed on [DATE]. An acceptable Removal Plan, which removed the immediacy of the Jeopardy for F-602 was received on [DATE]. The corrective actions were validated onsite by the surveyor on [DATE] through observation, review of records, audit review, education review, and staff interviews. Noncompliance continues for F-602 at a scope and severity of E. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	The facility is required to submit a Plan of Correction. The findings include: 1. Review of the facility's policy titled Abuse, Neglect and Misappropriation of Property dated [DATE], and revised [DATE], revealed .It is the organization's intentions to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property, and to assure all alleged violations of federal or State laws which involve abuse, neglect, exploitation, injuries of unknown origin, and misappropriation are investigated and reported immediately .Definitions: .Misappropriation of resident property Is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent . Review of the facility's policy titled Controlled Medications dated [DATE], revealed .The facility will ensure Controlled Medications are handled, stored, disposed of, and recordkeeping is in place in accordance with federal, state, and other applicable laws and regulations . 1. A controlled medication accountability record is prepared when receiving or checking in a Schedule II, III, IV, or V medications. The following information is compiled in the report: a. Name of resident. b. Prescription number. c. Name, strength, and dosage form of medication. d. Date received. e. Quantity received. f. Name of person receiving medication supply. 2. At each shift change or when keys are rendered, a physical inventory of all controlled medication is conducted by two staff members who are either licensed nurses, medication technicians, or appropriate staff per state regulations and is documented on the controlled medications accountability record .Once the medications count is completed, both licensed nurses or medication technicians will also count the number of individual narcotic control sheets, together and will sign the controlled medication accountability record .If a new medication is added or a medication is discontinued/removed, the controlled medication accountability record must reflect the above by completing the controlled medication accountability record by two licensed nurses or medication technicians .3.Current controlled medication accountability records are kept in the narcotic book. When completed the accountability records are submitted to the director of nursing and maintained on file at the facility .6. Any controlled medications that have been competed including empty medication cards, discontinued, or are from a resident being discharged will be left on the medication cart and continued to be counted, as detailed in #2 above, until 2 nurse leaders remove the completed, discontinued, or discharged medications together . (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	2. Review of the medical record revealed Resident #1 was initially admitted on [DATE], and readmitted on [DATE], with diagnoses of Pain in Joints of Right Hand, Dysarthria (slurred speech) and Anarthria (complete loss of speech), Neuropathy, Type 2 Diabetes, Cerebrovascular Disease, Migraine, Seizures, Chronic Respiratory Failure, and Right Bundle Branch Block (a problem with the heart's electrical signal). Review of a Physician's Order for Resident #1 with a start date of [DATE], and no end date revealed an order for Oxycodone/Acetaminophen Schedule II ,d+[DATE] milligrams (mg) tablet give 1 tablet by mouth three times daily. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had a Brief Interview of Mental Status (BIMS) score of 14, which indicated no cognitive impairment. Review of the Pharmacy Manifest delivery records, the Controlled Substance Count sheets and the Controlled Drug Record sheets revealed the pharmacy delivered 263 tablets of Oxycodone 10 mg to the facility for Resident #1 on [DATE], [DATE], and [DATE]. Resident #1 had a total of 48 Oxycodone 10 mg tablets missing from those deliveries during the time of [DATE] through [DATE]. Review of the Controlled Substance Count sheet dated February 2024, revealed Resident #1 had Oxycodone 10 mg 1 card removed and 1 sheet removed from the controlled count. The Inventory Shift Count column was dated [DATE] (on the sheet for February) 6 PM and the columns for total number of cards had the number 28 written over another number and words in writing stated Twenty 8ish + [plus] 2. During an interview with the DON on [DATE] at 2:23 PM, when asked if there should be a witness when a Controlled Substance Count sheet and/or a Controlled Record Count sheet was added and/or removed from the count, the DON stated, A 2nd nurse should sign, but sometimes they don't. When asked what the Twenty 8ish + 2 meant on the Controlled Substance Count sheet, the DON stated, I can't answer that. 3. Review of the medical record revealed Resident #2 was admitted on [DATE], with diagnoses of Rheumatoid Arthritis, Pain Unspecified, History of Chronic Viral Hepatitis C, Atrial Fibrillation, Coronary Bypass Graft, Atherosclerotic Heart Disease, and Type 2 Diabetes. Resident #2 was scheduled to be discharged home on [DATE], but expired in the facility on [DATE]. Review of the admission MDS assessment dated [DATE], revealed Resident #2 had a BIMS score of 15, which indicated no cognitive impairment. Review of a Physician's order for Resident #2 with a start date of [DATE], and end date of [DATE], revealed an order for Oxycodone Schedule II 5 mg tablet give 1 tablet by mouth every 6 hours for pain. Review of the Pharmacy Manifest delivery records, the Controlled Substance Count sheets and the Controlled Drug Record sheets revealed the pharmacy delivered a total of 402 tablets of Oxycodone 5 mg for Resident #2 on [DATE], [DATE], and [DATE]. Resident #2 had a total of 61 Oxycodone 5 mg tablets missing. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on [DATE] at 8:47 AM, LPN E was asked if there had been any concerns with controlled narcotic counts on [DATE] when she had counted at shift change. LPN E stated, .The card of Oxycodone [for Resident #2] was gone. I can't remember the count. I feel comfortable saying the first line of tablets was empty and the rest of card I'm unsure [LPN E] could not recall the exact number of tablets], but I know he [Resident #2] had enough for several days. When I came back [returned to work on [DATE] after scheduled off days] there was no sheet [Narcotic sheet]. There was none. There was no sheets [Count sheets or Narcotic sheets] . During an interview with the DON on [DATE] at 3:10 PM, when asked when the facility identified Resident #2 had missing Oxycodone tablets, the DON stated, .The next morning [[DATE]] [Named LPN E] was here at 6:00 AM. She called me and asked where was the Fentanyl and oxy [Oxycodone] [was]. She thought there should have been a full box of Fentanyl and some oxy on a card. I asked her to look and see if the count of cards [for Resident #2] had been removed and she said yes by [Named LPN A]. There was no Fentanyl missing, only oxy missing. There should have been 51 tablets of the 86 received left on the card in the cart. This got me started looking at recently discharged or expired residents and then all residents with controlled medications. During an interview with Registered Nurse (RN) A on [DATE] at 5:49 PM, when asked if she witnessed the removal of any of Resident #2's medication cards from the Drug Record Count sheet on [DATE], RN A stated, .I was inside the room giving meds. She [LPN A] said she had some empty cards to sign out. She didn't bring them initially with her. I said what am I signing out. 2 nurses had to sign that a card [medication card] and a sheet [Narcotic sheet] was coming out of the book. She went back and got it .She handed me an empty card. I saw there were no tablets left in the card. I would have been the witness to the removal. When asked if she verified the medication and the count on the Controlled Drug Record sheet, RN A stated, No, I did not. RN A confirmed she did not verify the Narcotic sheet was accurate. 4. Review of the medical record revealed Resident #5 was admitted on [DATE], with diagnoses of Dementia, History of Traumatic Brain Injury, Fracture Upper End of Left Humerus, Chronic Obstructive Pulmonary Disease, History of Falling, Type 2 Diabetes, Vertigo, and Hypertension. Review of a Physician's order for Resident #5 with a start date of [DATE], revealed an order for Hydrocodone Schedule II 7.5mg tablet, give 1 tablet by mouth three times a day. Review of the quarterly MDS assessment dated [DATE], revealed Resident #5 had a BIMS score of 5, which indicated severe cognitive impairment. Review of the Pharmacy Manifest delivery records, the Controlled Substance Count sheets and the Controlled Drug Record sheets revealed the pharmacy delivered 351 tablets of Hydrocodone 7.5 mg to the facility for Resident #5 from [DATE] through [DATE]. Resident #5 had a total of 78 Hydrocodone 7.5 mg tablets missing and unaccounted for. 5. Review of the medical record revealed Resident #6 was admitted on [DATE], with diagnoses of Cirrhosis of Liver, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, Morbid Obesity, Obstructive Sleep Apnea, Congestive Heart Failure, and History of Myocardial Infarction. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of a Physician's order for Resident #6 with a start date of [DATE] revealed an order for Oxycodone Schedule II 5 mg tablet give every 6 hours as needed for pain. Review of the admission MDS assessment dated [DATE], revealed Resident #6 had a BIMS score of 14, which indicated no cognitive impairment. Review of the Pharmacy Manifest delivery records, the Controlled Substance Count sheets and the Controlled Drug Record sheets revealed the pharmacy delivered 118 tablets of Oxycodone 5 mg to the facility for Resident #6 on [DATE]. Resident #6 had 28 tablets of Oxycodone 5 mg missing and unaccounted for. 6. Review of the medical record revealed Resident #7 was initially admitted on [DATE], and readmitted on [DATE], with diagnoses of Malignant Neoplasm of Supraglottis [the upper part of the voice box], Malignant Neoplasm of Lymph Nodes, Cirrhosis of Liver, Tracheostomy Status, Cerebral Infarction, Viral Hepatitis C, and Acute Respiratory Failure. Review of a Physician's order for Resident #7 with a start date of [DATE], revealed an order for Oxycodone Schedule II 10 mg tablet give every 6 hours as needed for pain. Review of the admission MDS assessment dated [DATE], revealed Resident #7 had a BIMS score of 15, which indicated no cognitive impairment. Review of the Pharmacy Manifest delivery records, the Controlled Substance Count sheets and the Controlled Drug Record sheets revealed the pharmacy delivered 356 tablets of Oxycodone 10 mg to the facility for Resident #7 on [DATE] through [DATE]. Resident #7 had 94 tablets of Oxycodone 10 mg missing and unaccounted for. 7. Review of the medical record revealed Resident #8 was initially admitted on [DATE] with diagnoses of Congestive Heart Failure, Diabetic Neuropathy, Type 2 Diabetes, Bipolar Disorder, Peripheral Vascular Disease, Chronic Venous Ulcer Bilateral Lower Extremities, and Chronic Obstructive Pulmonary Disease. Review of a Physician's order for Resident #8, with a start date of [DATE], revealed an order for Hydrocodone/Acetaminophen Schedule II ,d+[DATE] mg tablet give every 6 hours as needed for pain. Review of the admission MDS assessment dated [DATE], revealed Resident #8 had a BIMS score of 15, which indicated no cognitive impairment. Review of the Pharmacy Manifest delivery records, the Controlled Substance Count sheets and the Controlled Drug Record sheets revealed the pharmacy delivered 348 tablets of Hydrocodone 5 mg to the facility for Resident #8 on [DATE] and [DATE]. Resident #8 had 144 tablets of Hydrocodone 5 mg missing and unaccounted for. 8. Review of the medical record revealed Resident #9 was admitted on [DATE], with diagnoses of Dementia, Peripheral Vascular Disease, Major Depression, Pain Unspecified, Restless Leg Syndrome, Repeated Falls, and Type 2 Diabetes. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of a Physician's order for Resident #9 dated [DATE], revealed an order for Hydrocodone/Acetaminophen Schedule II ,d+[DATE] mg tablet give every 12 hours as needed for pain to right hip. Review of the quarterly MDS assessment dated ,d+[DATE], revealed Resident #9 had a BIMS score of 15, which indicated no cognitive impairment. Review of the Pharmacy Manifest delivery records, the Controlled Substance Count sheets and the Controlled Drug Record sheets revealed the pharmacy delivered 116 tablets of Hydrocodone 5 mg to the facility for Resident #9 on [DATE]. Resident #9 had 56 Hydrocodone 5 mg tablets missing and unaccounted for. During an interview with the DON on [DATE] at 11:46 AM, the DON confirmed the Oxycodone and Hydrocodone tablets for Resident #1, #2, #5, #6, #7, #8, and #9 could not be accounted for due to missing Narcotic sheets and missing medication cards that were removed from the medication cart and were not completed. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on [DATE], and was validated onsite by the surveyor on [DATE] through review of staff education and sign-in sheets, observations, interviews with staff and Administration, and review of the audits conducted as follows: Corrective actions for identified residents affected by the deficient practice. 1.Residents #2 and #7 are deceased . 2.Resident #6 discharged from the facility on [DATE]. Charges to his insurance was reversed and charged to the facility. 3.On [DATE] Resident #1 was assessed for pain, no pain was noted and on [DATE], current residents #1, #5, #8 and #9 were assessed for pain by the DON. No pain was noted. 4.On [DATE] and [DATE] controlled medications were reconciled on every medication cart by the DON. This was completed on [DATE] and [DATE]. 5.On [DATE] the pharmacy was informed of the missing medications for residents #1, #5, #8, and #9. The charges to their insurance for their medications were reversed and charged to the facility. Identification of other elders who may be affected by the deficient practice and corrective actions that will be put in place to ensure the deficient practice does not reoccur. 1.Beginning [DATE] the DON and SCC conducted interviews with licensed staff to inquire if they had knowledge of controlled medication unaccounted for or if they had suspicion of anyone working while impaired. The interviews were completed on [DATE]. 2.On [DATE], the DON and SCC began auditing the Controlled Medication delivery logs for Resident #1 to ensure all deliveries were added to carts #1 and #2 on Hall #3. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	3.On [DATE], the DON and SCC began auditing the Controlled Drug Records for residents that were recently discharged or deceased from Hall #3. Beginning [DATE] an audit of controlled medication logs from [DATE] to [DATE] was conducted for every resident in the facility with an order for a controlled medication to determine if other nurses/residents were involved. This was performed by the DON and SCC. The audit was completed on [DATE]. Hall #3 was the only hall identified with controlled medications unaccounted for. Any findings were reported to the legal and regulatory authorities: Health Facilities Commission, [NAME] TN Regional Office; TN Bureau of Investigation; [NAME] Police Department, Ombudsman and APS. 4.On [DATE], the affected residents with a BIMS of 8 or greater were interviewed by the DON, and all stated they received their pain medications, and all denied pain. 5.On [DATE], the affected resident with a BIMS less than 8 was assessed for pain by the DON, there was no complaint or signs of pain. 6.On [DATE], pain assessments were completed for all residents on Hall #3 by the nurse managers to determine if any had uncontrolled pain. There were no residents experiencing uncontrolled pain. 7.On [DATE], the nurse managers interviewed residents on Hall #3 with a BIMS equal or greater than 8 to determine if their pain is controlled and as needed (PRN) medications had been administered when requested. All stated their pain is controlled and they receive their PRN medications when requested. 8.On [DATE], the DON reviewed documented pain levels for uncontrolled pain. No one had uncontrolled pain levels. 9.One nurse was suspended on [DATE] due to reasonable suspicion and remains suspended. This nurse was reported to the Tennessee (TN) Board of Nursing on [DATE]. The TN Bureau of Investigation is continuing the investigation. Measures put in place and systemic changes you will make to ensure that the deficient practice does not reoccur: 1.a. A root cause analysis was conducted on [DATE]. It was determined that the nurse did not follow the process for removing controlled medications; obtaining a witness to verify the removal of controlled medications. The process was changed to prevent the nurses/medication aides from removing completed medication cards or discontinued medication cards. The DON or Unit Managers will remove controlled medications from the medication cart; completed medication cards/sheets and discontinued medication cards/sheets. b. A root cause analysis was conducted on [DATE]. It was determined the excess controlled medication cards/sheets did not need to be on the medication cart. A cabinet with 2 locks was secured in the medication room for overflow-controlled medications and a new form was developed, Controlled Substance Overflow Sheet, to record the addition and removal of controlled medication to that cabinet. 2.Beginning [DATE], education was conducted by the Director of Nursing (DON) and Staff Development Coordinator (SDC) with all staff on the Abuse and Misappropriation Policy. This was completed on [DATE]. Any staff/agency staff who were not educated will be before working their next shift. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	3.Beginning [DATE], education was conducted by the DON and SDC with all licensed staff and Medication Aides on the Controlled Medication Policy and process changes for counting/receiving/removing controlled medication. This was completed on [DATE]. Any staff/agency staff who were not educated will be educated prior to working their next shift. 4.Two nurses will verify the pharmacy delivery manifests for controlled medications in the presence of the driver. Once the quantity has been verified, they will sign the pharmacy delivery manifest. Two nurses will sign the Controlled Drug Record sheet and indicate the total quantity for the prescription (RX) number and the number of medication units, i.e. tablets, on the Controlled Drug Record sheet. Once the quantities are verified the two nurses will add the controlled medications to the medication cart and sign them into the Controlled Substance Record sheet. 5.Beginning [DATE] the Unit Managers will audit the pharmacy delivery manifests, daily, to verify controlled medications and Controlled Drug Record Sheets were added to the Controlled Substance Count Sheet and for count accuracy. 6.Beginning [DATE], the DON/UM will remove all controlled medications with a witness (empty and discontinued) from the medication cart, reconcile the Controlled Substance Count Sheets and compare the Controlled Substance Count Sheets to the Controlled Drug Records as they are removed from the cart to be secured for destruction. No one will remove controlled medication card/sheets without the DON/UM witnessing. This process, along with the process in #5 above, will prevent the ability to remove a count sheet and medication card without being discovered. 7.On [DATE] a secured cabinet with 2 locks was placed in the Four Seasons (hall #2) medication storage room. Overflow of controlled medications will be stored in the secured cabinet. The cabinet has 2 locks with 2 separate keys that are assigned to 2 different licensed nurses (the DON and SDC). The DON and SDC will access the controlled medication cabinet as needed: when multiple cards/sheets are delivered and as the nurses need medications due to running out on the cart. The carts will be checked at the end of the day and before the weekend to ensure the residents will not miss a dose of their controlled medication. The transaction will be recorded on the Controlled Substance Overflow sheet. There will not be a key to this cabinet on any other key ring. In the event the DON or SDC are not in the facility, the DON will designate a Clinical Manager to hold one key. 8.Beginning [DATE], the licensed nurses/medication aides were educated by the DON, SDC or UM. This was completed on [DATE]. Any licensed staff including agency nurses that were not educated will be before their next shift. Describe the Quality Assurance and Process Improvement Program (QAPI) put into place. 1.An Ad Hoc QAPI was held on [DATE], via phone, with Corporate Leadership, SCC, Pharmacy [NAME] President (VP) Strategic Accounts, and the Medical Director to discuss new findings and ongoing investigation. 2.An Ad Hoc QAPI was held on [DATE] with Corporate Leaders to discuss audit findings, via phone. 3.An Ad HOC QAPI was held on [DATE] with the Medical Director to discuss the event and plan of correction. (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	4.An Ad HOC QAPI was held on [DATE] with the Medical Director, to discuss implementation of a secured overflow cabinet for controlled medications, the process for accessing the cabinet and the recording of adding/removing controlled medications. This new process will be discussed in QAPI meetings to ensure compliance and determine any changes that may be warranted. 5.Beginning [DATE], the Clinical Interdisciplinary Team (IDT) will audit every scheduled nurse at shift change for accuracy of the count process daily for two weeks then, weekly times (x) 2 weeks, then monthly x 2 months, then quarterly thereafter. 6.Beginning [DATE] the DON/Unit Manager (UM) will audit the medication carts to ensure discontinued/completed controlled medications have been removed from the cart and the Controlled Medication Count Sheet accurately records the removal 5 times per week x 2 weeks then, 3 times per week x 2 weeks then, 2 times monthly x 2 months. 7.Beginning [DATE] the DON will conduct random audits of the Pharmacy Delivery Report to ensure the delivered controlled medications were accurately added to the medication carts and Controlled Substance Count Sheets; 5 deliveries per week x 2 weeks then, 3 deliveries per week x 2 weeks then, 3 deliveries per month x 2 months. 8.The Quality Assurance (QA) Team will review staff education and QA audits for completion and accuracy. Findings of audits will be reported to the QAPI Committee which includes the Administrator, DON, Unit Managers, SDC, Social Services Director, Maintenance Director, Dietary Manager, Life Enrichment Director, Rehab Manager, and Medical Director. The QAPI meetings will be held weekly beginning [DATE] for 4 weeks then, 2 times per month for the next 30 days then, monthly thereafter or until the QAPI Committee determines substantial compliance has been achieved. The QAPI Committee reserves the right to modify or extend monitoring times according to outcomes. Regional oversite has been in place daily since [DATE]. The Senior (Sr.) Signature State Care Consultant has been in the facility assisting with interviews, education, audits, process changes, attending Ad Hoc QAPI meetings and oversight of compliance with process changes. Regional oversite has occurred onsite or by phone from the Sr. Signature State Care Consultant, the Regional VP of Clinical Operations, or the Regional VP of Operations. The Regional team has collaborated with the facility team on process changes and attended Ad HOC QAPI meetings via phone to discuss audit findings and develop a plan of correction.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28913 Based on medical record review and interview, the facility failed to provide effective pain management for 1 of 9 (Resident #3) sampled residents reviewed for pain management. Resident #3 received Tylenol per physician standing orders, but the Tylenol was not effective as Resident #3 continued to complained of pain. The facility's failure to effectively manage Resident #3's pain and follow up on imaging with continued complaints of pain post fall, resulted in Actual Harm when Resident #3 had a displaced comminuted fracture involving the distal femur. The findings include: 1. Review of the medical record revealed Resident #3 was admitted on [DATE], with diagnoses of Dementia, History of Falling, Chronic Obstructive Pulmonary Disease, Hypertension, Pain, Muscle Weakness, Comminuted Fracture of Right Distal Right Femoral Shaft, Intertrochanteric Fracture Left Femur, and Vertebral Lumbar Spine Compressions. Review of the quarterly Minimum Data Set assessment dated [DATE], revealed Resident #3 had a Brief Interview of Mental Status score of 4, which indicated severe cognitive impairment. Review of a standing Physician's order for Resident #3 with a start date of 11/7/2023, revealed an order for Tylenol 325 milligrams (mg) give 2 tablets four times a day as needed for pain. Review of the Progress Notes for Resident #3 dated 11/6/2023 7:20 AM, revealed .Elder [Resident #3] lying in the floor between foot of roommates bed and wall .elder [Resident #3] complained of hip pain .elder [Resident #3] reported pain in hips but only when she moved. Elder declined need for any medication for pain . Review of the Progress Note for Resident #3 dated 11/6/2023 1:15 PM, revealed .Elder [Resident #3] had fall and complaining of bilateral hip pain. MD [medical doctor] notified new order to obtain Bilateral hip x-ray. Results received with no issues noted . Review of the Radiology Report dated 11/6/2023 for bilateral hip x-ray, revealed .No acute fracture or dislocation .Conclusion: .Recommend a repeat multi-view imaging in 1 week or sooner if clinically warranted especially if symptoms continue to persist or progress . The resident continued to complain of pain and no additional repeat of imaging was performed until 11/14/2023, when the resident's family requested additional imaging on 11/14/2023. Review of the November 2023 Medication Administration Record (MAR) revealed no medication was administered for pain on 11/6/2023 for Resident #3's complaint of pain. Review of a Progress Note for Resident #3 dated 11/7/2023 1:04 PM, revealed .elder [Resident #3] c/o [complains of] pain in B [bilateral] hips .elder states the pain increases when moving legs. Standing order for Tylenol added to emar [electronic Medication Administration Record] .will place on MD list due to cont'd [continued] pain in B hips . The Physician was not notified of Resident #3's increased pain on 11/7/2023. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445377	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Erin	278 Rocky Hollow Road Erin, TN 37061

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of a Physician progress note dated 11/8/2023, revealed the following, .Seen and examined following fall. Complaining of soreness in the left hip, states that she had surgery [confused and thinking she had been to surgery] on the hip yesterday. Xray was negative for fracture. Review of Progress Note for Resident #3 dated 11/10/2023 3:34 PM, revealed .Elder complaining of 10/10 R [right] hip pain .Elder reports the 650 mg apap [Tylenol] PO [by mouth] does not relieve pain. After 650 mg apap elder's pain is 6/10 [pain scale of 0-10] to the R hip . Review of the November MAR for Resident #3 revealed Tylenol was administered 11/10/2023 at 5:20 AM and was not effective and administered again at 3:33 PM and was not effective. Review of an Occupational Therapy Treatment note dated 11/10/2023, revealed .elder exhibiting hollering and shaking when moving .increased discomfort in R hip . Review of a Stop and Watch (a form to document noted change in condition) dated 11/10/2023, revealed Resident #3 had increased pain to touch to right hip reported to nursing from the Therapy Department. Review of a Progress Note for Resident #3 dated 11/12/2023 2:15 PM, revealed .Elder yells in pain every time elder is moved. Reports that hip has 8/10 pain when moved or touched. PRN [as needed] Tylenol given with slight effectiveness .elder not wanting to get OOB [out of bed] and move leg. Placed on MD rounds for cont'd increased pain . Review of the November MAR dated 11/12/2023 revealed the following results of pain assessed: a.11/12/2023 at 8:37 AM pain rated as 3/10 with Tylenol administered was somewhat effective b.11/12/2023 at 1:52 PM pain rated as 6/10 with Tylenol administered. Nurse's progress note documented slight effectiveness. c.11/12/2023 at 7:12 PM pain rated as 8/10 using facial expression scale, Tylenol administered as O* [Other comment]. Review of Progress Note for Resident #3 dated 11/13/2023 9:35 PM, revealed .Elder yells out in pain every time she moves her rt [right] leg. Started Tramadol this evening . Review of a Progress Note dated 11/14/2023 9:56 AM, revealed .right upper leg per family request. MD made aware . Review of a Progress Note dated 11/14/2023 10:12 AM, revealed .Family also requested the right knee, lumbar spine, and coccyx also be x-rayed . MD aware . Review of a Progress Note dated 11/14/2023 10:50 AM revealed .Elder [Resident #3] continues to c/o discomfort during care . (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of a Progress Note dated 11/14/2023 1:52 PM, revealed .Spoke with family concerning acute right femoral fx [fracture] and vertebral compressions which family states they know no hx [history] of. Family stated that they want her sent to [Named hospital] for eval and tx [treatment] . MD made aware . The resident was sent to the hospital ED. Review of a Radiology Report dated 11/14/2023 for x-ray of right tibia and fibula, revealed .Results: Fracture of the distal femoral shaft with malignment .Conclusion: Acute appearing femoral fracture . Review of a Radiology Report dated 11/14/2023 for x-ray of right knee, revealed .Results: Mild to modestly displaced, comminuted fracture involving the distal femur . Review of a Radiology Report dated 11/14/2023 for x-ray of lumbar spine, revealed .Results: Vertebral compressions are seen at T-12, L-1, and L-2 vertebral bodies .Conclusion: . Correlation is needed with history, symptomatology, and physical exam to determine precise acuity . Review of the Hospital History and Physical from Resident #3's admitted d 11/14/2023, revealed .presents to the ED [Emergency Department] from Signature Healthcare in [NAME] with acute fracture of the intertrochanteric left femur and comminuted fracture of distal right femoral shaft noted on the x-ray obtained on presentation to the ED .patient [Resident #3] continued to complain of pain to both hip, unable to get up or bear weight on both legs; she was being given tramadol as needed for the pain .Assessment/Plan Leg injury . plan OR [operating room] bilateral femur fixation 11/16 [2023] . 2. During an interview on 3/14/2024 at 9:20 AM, when Certified Nursing Assistant (CNA) was asked if Resident #3 complained of pain, CNA #3 stated, .She had pain in hips and lower back for several days .not full relief most days. She had yelling out when moved . During an interview on 4/2/2024 at 12:15 PM, when asked how would a resident that had confusion and could not express their pain level be evaluated, RN A stated, Usually can tell by facial expressions and when you try and position different. If significant pain such as crying, screaming, yelling out, saying they are hurting should let the MD or NP know if pain is not relieved or increases. When asked what number on a scale of 0-10 would be significant pain, RN A stated, 6 would be significant. During an interview on 4/3/2024 at 11:50 AM, when LPN K was asked if Resident #3 complained of pain, LPN K stated, .She had confusion, couldn't really tell us or rate her pain. She had moaning, grimacing, and irritability. When asked when the physician should be notified of a resident's pain, LPN K stated, Should contact MD immediately if I thought Tylenol wasn't going to bring relief or the med [medication for pain] didn't relieve . During an interview on 4/3/2024 at 1:30 PM, when the primary Physician was asked if he had assessed Resident #3 after the fall on 11/6/2023, he stated, .I was called when she had the fall. She was on my list to see a couple days after she fell . When I saw her she was in bed. She said she had soreness and had surgery the day before. She didn't appear to be in pain. When asked if a pain medication was ordered, the primary Physician stated, Not at that time. They had standing orders. [order for Tylenol 650 mg as needed] .

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	445377	A. Building B. Wing	04/03/2024

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	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** 28913 Based on facility policy review, Pharmacy Services agreement, facility investigation review, review of facility medication reconciliation documents, and interview, the facility failed to have a system of recording, accurate reconciliation, and accounting for all controlled medications, failed to promptly identify loss or potential diversion of controlled medications, and failed to timely determine the extent of loss or potential diversion of controlled medications for 7 of 9 (Resident #1, #2, #5, #6, #7, #8, and #9) sampled residents reviewed with orders for controlled narcotics. On [DATE] the medication nurse (LPN E) discovered that Resident #2's Fentanyl transdermal patch had been tampered with, no actions were taken at that time on [DATE]. On [DATE] the facility discovered Resident #1 and #2's Fentanyl transdermal patches had been tampered with (cut open and resealed), which possibly diverted the prescribed controlled medication for pain control for Resident #1 and #2. The facility failed to test or seek expert identification for the Fentanyl medication patch in the resealed package. On [DATE] it was discovered the Oxycodone and Hydrocodone narcotic count reconciliations were not accurate. Review of the facility's narcotic reconciliation documents from [DATE] through February 2024 revealed Residents #1, #2, #5, #6, #7, #8, and #9 had a combined total of 509 Oxycodone and Hydrocodone narcotic tablets missing, the facility was unable to account for the missing 509 narcotic tablets. The facility's failure to ensure a system was in place for records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate and timely reconciliation and accounting for all controlled drugs was maintained and prompt identification of loss or potential diversion resulted in Immediate Jeopardy for Residents #1, #2, #5, #6, #7, #8, and #9. Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Interim Administrator, the Director of Nursing (DON), and the Regional Significant Care Coordinator were notified of the Immediate Jeopardy for F-755 on [DATE] at 1:08 PM in the Conference Room. F-755 was cited at a scope and severity of K. A partial extended survey was conducted from [DATE] through [DATE]. The Immediate Jeopardy began [DATE], continued through [DATE], and was removed on [DATE]. An acceptable Removal Plan, which removed the immediacy of the Jeopardy for F-755 was received on [DATE]. The corrective actions were validated onsite by the surveyor on [DATE] through observation, review of records, audit review, education review, and staff interviews. Noncompliance continues at F-755 at a scope and severity of E. The facility is required to submit a Plan of Correction. The findings include: (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	1.Review of the facility's policy titled Controlled Medications dated [DATE], revealed .The facility will ensure Controlled Medications are handled, stored, disposed of, and recordkeeping is in place in accordance with federal, state, and other applicable laws and regulations .1. A controlled medication accountability record is prepared when receiving or checking in a Schedule II, III, IV, or V medications. The following information is compiled in the report: a. Name of resident. b. Prescription number. c. Name, strength, and dosage form of medication. d. Date received. e. Quantity received. f. Name of person receiving medication supply. 2. At each shift change or when keys are rendered, a physical inventory of all controlled medication is conducted by two staff members who are either licensed nurses, medication technicians, or appropriate staff per state regulations and is documented on the controlled medications accountability record .Once the medications count is completed, both licensed nurses or medication technicians will also count the number of individual narcotic control sheets, together and will sign the controlled medication accountability record .If a new medication is added or a medication is discontinued/removed, the controlled medication accountability record must reflect the above by completing the controlled medication accountability record by two licensed nurses or medication technicians .3. Current controlled medication accountability records are kept in the narcotic book. When completed the accountability records are submitted to the director of nursing and maintained on file at the facility .6. Any controlled medications that have been completed including empty medication cards, discontinued, or are from a resident being discharged will be left on the medication cart and continued to be counted, as detailed in #2 above, until 2 nurse leaders remove the completed, discontinued, or discharged medications together .7. Controlled medications remaining in the facility after the order has been discontinued or due to residents being discharged are retained in the facility in a securely locked area with restricted access until destroyed by 2 nurse leaders and/or 1 nurse leader and a consultant pharmacist; or otherwise by state law . 2. Review of the Pharmacy Services Agreement dated [DATE], revealed .Consulting Services .Pharmacy shall appoint a Pharmacy representative to serve on the Customer's Quality Assurance (QA) Committee and/or Pharmaceutical services committee .Additional Services. Upon client's request, Pharmacy shall provide the following and any other additional consulting services .b) Consult with the Client's staff as to its compliance with Applicable Law with respect to the destruction of unused Medications, including, but not limited to, controlled substances. Pharmacy shall assist in the accounting, destruction, and reconciliation of unused Medications .d) Perform random quarterly audits of medication carts or audit medication storage areas for controlled and non-controlled medications. E) Perform on-site audits of Medical Records, contents of medication carts and/or Resident treatment charts, if provided by Pharmacy .Nurse Consulting Services . Perform a Narcotics Review with documentation review for the protection of facility staff and residents . Perform a Root Cause Analysis to determine process gaps and provide written solutions for both Pharmacy and Client issues . (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	3. Review of a facility's investigation and survey investigation findings revealed on [DATE], Licensed Practical Nurse (LPN) E discovered Resident #2's Fentanyl pack had been tampered with, there were no actions taken by the facility on [DATE]. On [DATE], LPN B discovered Resident #2's Fentanyl patches had been tampered with, and then checked Resident #1's Fentanyl patches and discovered that both Resident #2's and Resident #1's Fentanyl patches had been tampered with resulting in a diversion of the medication. a. Review of the medical record revealed Resident #1 was initially admitted on [DATE], and readmitted on [DATE], with diagnoses of Pain in Joints of Right Hand, Dysarthria and Anarthria, Neuropathy, Type 2 Diabetes, Cerebrovascular Disease, Migraine, Seizures, Chronic Respiratory Failure, and Right Bundle Branch Block. Review of a Physician's order dated [DATE] for Resident #1, with no end date, revealed an order for Fentanyl transdermal patch 25 micrograms (mcg) apply once a day every 3 days for pain. Review of a Pharmacy manifest sheet dated [DATE] and [DATE], revealed 10 Fentanyl transdermal patches [2 boxes of 5] were delivered for Resident #1 on each date. There was no signature of verification of receipt for either delivery. b. Review of the medical record revealed Resident #2 was admitted on [DATE] with diagnoses of Rheumatoid Arthritis, Pain Unspecified, History of Chronic Viral Hepatitis C, Atrial Fibrillation, Coronary Bypass Graft, Atherosclerotic Heart Disease, and Type 2 Diabetes. Resident #2 was schedule to be discharged home on [DATE], but expired in the facility on [DATE]. Review of a Physician's order for Resident #2 dated [DATE], revealed an order for Fentanyl transdermal patch 50 mcg apply once a day every 3 days for pain. Review of a Physician's order for Resident #2 dated [DATE], revealed an order for Fentanyl transdermal patch 75 mcg apply once a day every 3 days for pain. Review of the Pharmacy manifest sheets for Resident #2 dated [DATE] for 1 box totaling 5 Fentanyl patches, [DATE] for 2 boxes totaling 10 Fentanyl patches, [DATE] for 2 boxes totaling 10 Fentanyl patches, and [DATE] for 2 boxes containing 10 Fentanyl patches, revealed there was no facility nurses' signature of verification of receipt for all 3 deliveries. Review of the Narcotic sheet for Fentanyl 50 mcg patch, belonging to Resident #2, with a start date of [DATE], revealed there were 5 patches in the box in use. Documentation on the Narcotic sheet revealed 1 patch was removed from the count on [DATE] at 2:00 PM, 1 patch was removed from the count on [DATE] at 9:45 AM, and 1 patch was removed on [DATE] at 10:00 AM but no administered to Resident #2. Review of the Narcotic sheet for Fentanyl 75 mcg patch, belonging to Resident #2, with a start date of [DATE], revealed there were 5 patches in the box in use. Documentation on the Narcotic sheet revealed 1 patch was removed from the count on [DATE] at 10:00 PM, 1 patch was removed from the count on [DATE] at 6:00 PM, 1 patch was removed from the count on [DATE] at 6:30 PM, 1 patch was removed from the count on [DATE] at 7:00 PM, and 1 patch was removed from the count on [DATE] at 3:00 PM. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	c. Review of a facility investigation dated [DATE], revealed Licensed Practical Nurse (LPN) B discovered Resident #1 and #2's Fentanyl transdermal patches had been opened, resealed, and placed back in the packaging boxes causing a diversion of the medication. Resident #2's Fentanyl patches were first discovered to have been tampered with, afterwards, Resident #1's Fentanyl patches were discovered to have also been tampered with. Review of a written witness statement dated [DATE] from the facility investigation file and signed by LPN B, revealed .Date Incident Occurred: [DATE] .When attempting to place a fentanyl patch on an elder [Resident #2] I was unable to remove the patch from the plastic. I went to get another patch and the patch appeared the same as the other patch. I noticed the pack [individual package containing the Fentanyl patch] was torn so I compared his pack to another elder's [Resident #1] and found two of her four patch [patches] appeared to have been opened and resealed as well. I then contacted the DON . Review of a written witness statement dated [DATE] from the facility investigation file and signed by LPN F, revealed .Date Incident Occurred: [DATE] .Named LPN [LPN B] called me to come over to Brandywood [Hall 300]. When I arrived Named LPN [LPN B] had the boxes of fentanyl patches on the top of the cart and showed me the patches/packaging. The packaging was cut and resealed. Some of the fentanyl patches were bubbled and off in color d. During an interview with the DON on [DATE] at 2:00 PM, when asked about the Fentanyl patches that had been tampered, the DON stated, .She [LPN B] tried to remove 1 patch from the covering [on [DATE] for Resident #2] and it was difficult and stretched. She then went to get another one and it was the same. Then noticed what looked like a substance dried like school glue . The DON stated she opened an unused box of 5 Fentanyl patches belonging to Resident #1 and the same substance that looked like glue was there. The DON stated, Named Resident [Resident #1] had 4 patches in the opened box. Each package had a cut on the back of the pkg. When I opened the patch cover the [Fentanyl] patch looked used [looked like it had already been used]. There was air bubble-like spots [on the patch] . During an interview with LPN G on [DATE] at 3:20 PM, when asked if the Pharmacy manifest sheet was signed by a nurse to verify the delivery of medications, LPN G stated, We have to count with Pharmacy now when delivered. We didn't sign on the Pharmacy sheet before this [discovery of missing narcotics and Fentanyl tampering]. During an interview with LPN E on [DATE] at 8:47 AM, when asked if the Pharmacy manifest sheet was signed by a nurse to verify the delivery of mediations, LPN E stated, .Before all this [discovery of missing narcotics and Fentanyl tampering] started happening, we didn't have 2 nurses sign on this sheet [Count sheet]. Now we have to sign both. When asked to clarify both, LPN E stated, We have to sign the Pharmacy sheet [and the Controlled Count sheet]. During an interview of [DATE] at 9:21 AM, LPN D stated, .The only time I had noticed anything was on Friday [DATE]. [Named LPN E] brought me a patch that still had the backing on it. She asked me if it looked odd. She had taken it out of the white sealed pack. It still had the clear backing. When I looked at it to me it looked like the edges may have been loosened, but they still appeared to be sealed. It was not clear around the edges. The center itself, the patch, was still attached The Unit Manager told her [LPN E] if package had been sealed it should be ok. This was on [Named Resident #2] . (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	During an interview on [DATE] at 2:15 PM, LPN H/Unit Manager stated, .Someone had tampered with the packages of Fentanyl a few days before this time [[DATE]]. LPN E brought me a patch [on [DATE]] and asked me if it looked odd or used. It was flat on the paper, but there was a few bubbles. It wasn't crooked on the paper or wrinkled. I looked at the package and it looked fine. I didn't turn the package over it was laying on the cart and I just looked at it. I said if it's from a fresh package it should be fine. I did say it could be used. When asked if the DON was notified of the patch appearance LPN H/Unit Manager stated, No, I didn't . During an interview with the DON on [DATE] at 3:13 PM, when asked if the Pharmacy manifest [delivery] sheets should be signed by a nurse to verify the medications were delivered, the DON stated, .On the 19th [[DATE]] our process was changed. Whenever they receive the controlled narcotics from pharmacy they have to verify what is in the delivery box, matched the delivery sheet. 4. Review of a facility investigation dated [DATE], revealed audits conducted beginning on [DATE], related to the Fentanyl transdermal patch tampering, led to a discovery on [DATE], that a Controlled Drug Record (Narcotic sheet, a sheet for documentation of removal of a tablet from the medication card) for Resident #2 had been removed from the Controlled Substance Count sheet (Count sheet- a form for documentation of the number of Narcotic Sheets and medication cards). When the DON went to obtain the Narcotic sheet from the folder of completed records, the Narcotic sheet for Resident #2 could not be located. There were 11 Narcotic sheets and 11 medication cards containing Oxycodone and Hydrocodone unaccounted for from [DATE] - [DATE]. From [DATE] - February 2024, Residents #1, #2, #5, #6, #7, #8, and #9 had Hydrocodone and Oxycodone missing and unaccounted for. 5. Review of a Physician's Order for Resident #1, with a start date of [DATE] and no end date, revealed an order for Oxycodone/Acetaminophen Schedule II 10mg/325 milligrams (mg) tablet give 1 tablet by mouth three times daily. Review of the Pharmacy manifest sheet dated [DATE], revealed 88 Oxycodone 10 mg tablets were delivered for Resident #1 on 1 card with 60 tablets and 1 card with 28 tablets. The Narcotic sheet and the card of 28 tablets belonging to Resident #1 were missing. Review of the Pharmacy manifest sheet dated [DATE], revealed 88 Oxycodone 10 mg tablets were delivered for Resident #1 on 1 card with 60 tablets and 1 card with 28 tablets. The Narcotic sheet for the card with the remaining 12 tablets from the card of 28 belonging to Resident #1 were missing. Review of the Pharmacy manifest sheet dated [DATE], revealed 87 Oxycodone 10 mg tablets were delivered for Resident #1 on 1 card of 27 tablets and 1 card of 60 tablets. The Narcotic sheet for the card of 27 tablets was started on [DATE] and would have been completed on [DATE]. This Narcotic sheet and medication card with the remaining 8 tablets belonging to Resident #1 were missing. Resident #1 had a total of 48 tablets of Oxycodone 10 mg tablets missing and unaccounted for between [DATE] - [DATE]. Review of the Count sheets for [DATE], revealed there was no documentation of the Pharmacy delivery of the 2 cards of Oxycodone 10 mg tablets for Resident #1. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the Count sheet dated [DATE] revealed initials that were marked through multiple times with no other initials entered from an oncoming shift change nurse to witness the narcotic count. Review of the Controlled Substance Count sheet dated February 2024, revealed Resident #1 had Oxycodone 10 mg 1 card removed and 1 sheet removed from the controlled count. The Inventory Shift Count column was incorrectly dated [DATE] for the sheet for February 2024. The column for total number of cards had the number 28 written over another number and words in writing stated Twenty 8ish + [plus] 2. During an interview with the DON on [DATE] at 2:23 PM, when asked if there should be a witness when a Controlled Substance Count sheet and/or a Controlled Record Count sheet was added and/or removed from the count, the DON stated, A 2nd nurse should sign, but sometimes they don't. When asked what the Twenty 8ish + 2 meant on Resident #1's Controlled Substance Count sheet, the DON stated, I can't answer that. The facility failed to ensure a second nurse always signed as a witness for added/removed medication card and sheets. 6. Review of the admission MDS assessment for Resident #2 dated [DATE], revealed Resident #2 had a BIMS score of 15, which indicated no cognitive impairment. Review of a Physician's order for Resident #2 with a start date of [DATE], and end date of [DATE], revealed an order for Oxycodone Schedule II 5 mg tablet give 1 tablet by mouth every 6 hours for pain. Review of the Pharmacy manifest sheet for Resident #2 dated [DATE], revealed 176 Oxycodone 5mg tablets were delivered for Resident #2 on 1 card with 86 tablets and 1 card with 90 tablets. The Narcotic sheet and remaining 10 tablets belonging to Resident #2 were missing. A new Narcotic count sheet for the card of 86 tablets was started on [DATE]. The Narcotic sheet and remaining 51 tablets belonging to Resident #2 were missing and unaccounted for. Resident #2 had a total of 61 Oxycodone 5 mg tablets missing and unaccounted for. Review of the Count sheet dated [DATE], revealed there was no 2nd nurse signature to verify the 176 Oxycodone 5 mg tablets were added to the count. 7. Review of the medical record revealed Resident #5 was admitted on [DATE], with diagnoses of Dementia, History of Traumatic Brain Injury, Fracture Upper End of Left Humerus, Chronic Obstructive Pulmonary Disease, History of Falling, Type 2 Diabetes, Vertigo, and Hypertension. Review of the quarterly MDS assessment dated [DATE], revealed Resident #5 had a BIMS score of 3, which indicated severe cognitive impairment. Review of a Physician's order for Resident #5 with a start date of [DATE], revealed an order for Hydrocodone/Acetaminophen 7XXX,d+[DATE] mg, give 1 tablet three times a day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445377	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the Pharmacy manifest sheet dated [DATE], revealed 90 Hydrocodone 7.5 mg tablets were delivered for Resident #5 on 1 card of 30 and 1 card of 60 tablets. On [DATE] there were 30 tablets were missing belonging to Resident #5. Review of a Physician's order for Resident #5 with a start date of [DATE], revealed an order for Hydrocodone Schedule II 7.5 mg tablet, give 1 tablet by mouth every 6 hours as needed for pain. Review of the Pharmacy manifest sheet dated [DATE], revealed 87 Hydrocodone 7.5 mg tablets were delivered for Resident #5 on 1 card of 27 tablets and 1 card of 60 tablets. Review of the Pharmacy manifest sheet for Resident #5 revealed on [DATE] the pharmacy delivered 87 Hydrocodone 7.5 mg tablets. On [DATE] there were 30 tablets missing belonging to Resident #5. Review of the Pharmacy manifest sheet dated [DATE], revealed 87 Hydrocodone 7.5 mg tablets were delivered for Resident #5 on 1 card of 27 tablets and 1 card of 60 tablets. On [DATE] there were 18 tablets missing belonging to Resident #5. Resident #5 had a total of 78 Hydrocodone tablets missing and unaccounted for. Review of the quarterly MDS assessment dated [DATE], revealed Resident #5 had a BIMS score of 5, which indicated severe cognitive impairment. 8. Review of the medical record revealed Resident #6 was admitted on [DATE], with diagnoses of Cirrhosis of Liver, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes, Morbid Obesity, Obstructive Sleep Apnea, Congestive Heart Failure, and History of Myocardial Infarction. Review of a Physician's order for Resident #6 with a start date of [DATE], revealed an order for Oxycodone Schedule II 5 mg tablet give every 6 hours as needed for pain. Review of the admission MDS assessment dated [DATE], revealed Resident #6 had a BIMS score of 14, which indicated no cognitive impairment. Review of a Pharmacy manifest sheet dated [DATE], revealed 118 Oxycodone 5mg tablets were delivered to Resident #6 on 1 card of 28 tablets and 1 card of 90 tablets. On [DATE], there were 28 tablets belonging to Resident #6 missing. Resident #6 had a total of 28 Oxycodone 5mg tablets missing and unaccounted for. 9. Review of the medical record revealed Resident #7 was initially admitted on [DATE], and readmitted on [DATE], with diagnoses of Malignant Neoplasm of Supraglottis [upper part of the voice box], Malignant Neoplasm of Lymph Nodes, Cirrhosis of Liver, Tracheostomy Status, Cerebral Infarction, Viral Hepatitis C, and Acute Respiratory Failure. Review of a Physician's order for Resident #7 with a start date of [DATE], revealed an order for Oxycodone Schedule II 10 mg tablet give every 6 hours as needed for pain. Review of the admission MDS assessment dated [DATE], revealed Resident #7 had a BIMS score of 15, which indicated no cognitive impairment. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of a Pharmacy manifest sheet dated [DATE], revealed 118 Oxycodone 10 mg tablets were delivered to Resident #7 on 1 card of 58 tablets and 1 card of 60 tablets. There were 37 of Resident #7's Oxycodone missing on [DATE]. Review of a Pharmacy manifest sheets dated [DATE], revealed 119 Oxycodone 10 mg tablets were delivered to Resident #7 on 1 card of 29 tablets and 3 cards of 30 tablets. On [DATE] there were 27 Oxycodone tablets missing, and on [DATE] there were 30 Oxycodone tablets missing. Review of the Pharmacy manifest sheet dated [DATE], revealed 119 Oxycodone 10 mg tablets were delivered to Resident #7. Resident #7 had a total of 94 Oxycodone 10 mg tablets missing and unaccounted for. 10. Review of the medical record revealed Resident #8 was admitted on [DATE], with diagnoses of Congestive Heart Failure, Diabetic Neuropathy, Type 2 Diabetes, Bipolar Disorder, Peripheral Vascular Disease, Chronic Venous Ulcer Bilateral Lower Extremities, and Chronic Obstructive Pulmonary Disease. Review of the quarterly MDS assessment dated [DATE], revealed Resident #8 had a BIMS score of 13 which indicated no cognitive impairment. Review of a Physician's order for Resident #8 with a start date of [DATE], revealed an order for Hydrocodone/Acetaminophen Schedule II ,d+[DATE] mg tablet give every 6 hours as needed for pain. Review of a Pharmacy manifest sheet dated [DATE], revealed 174 Hydrocodone 5mg tablets were delivered for Resident #8 on 2 cards of 60 tablets and 1 card of 54 tablets. Review of a Pharmacy manifest sheet dated [DATE], revealed 174 Hydrocodone 5 mg tablets were delivered for Resident #9 on 1 card of 24 tablets and 5 cards of 30 tablets. On [DATE] 30 tablets belonging to Resident #9 were missing. On [DATE] 114 tablets were belonging to Resident #9 were missing. Resident #8 had a total of 144 Hydrocodone 5 mg tablet missingand unaccounted for. Review of the admission MDS assessment dated [DATE], revealed Resident #8 had a BIMS score of 15 which indicated no cognitive impairment. 11. Review of the medical record revealed Resident #9 was admitted on [DATE], with diagnoses of Dementia, Peripheral Vascular Disease, Major Depression, Pain Unspecified, Restless Leg Syndrome, Repeated Falls, and Type 2 Diabetes. Review of the quarterly MDS assessment dated [DATE], revealed Resident #9 had a BIMS score of 15 which indicated no cognitive impairment. Review of a Physician's order for Resident #9 dated [DATE], revealed an order for Hydrocodone/Acetaminophen Schedule II ,d+[DATE] mg tablet give every 12 hours as needed for pain to right hip. (continued on next page)

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	445377	A. Building B. Wing	04/03/2024

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	Review of a Pharmacy manifest sheet dated [DATE], revealed 116 Hydrocodone 5mg tablets were delivered for Resident #8 on 1 card of 56 tablets and 1 card of 60 tablets. On [DATE] there were 56 tablets belonging to Resident #9 missing. Resident #9 had a total of 56 tablets of Hydrocodone 5 mg missing and unaccounted for. 12. During an interview on [DATE] at 10:52 AM, when asked if 2 nurses signed the Count sheet when a controlled narcotic was added or removed from the count, LPN I stated, If I use the last sheet [Narcotic sheet] I would sign out the sheet and take it out and the card .No, not always two nurses sign [when a controlled narcotic or count sheet was added or removed]. I guess that [2 nurses signatures] would be best . During an interview on [DATE] at 10:34 AM, when asked the process for reconciling the Narcotic sheets, LPN H/Unit Manager stated, I would get the narc [narcotic] sheets and file them [the narcotic and count sheets when the nurse removed them form the count]. I would look at sheet [narcotic sheet] to see if it looked right .I glanced down it and looked, not in detail at that time. I just filed away until someone asked for them. When asked how often the sheets were reconciled, LPN H/Unit Manager stated, Sometimes it would be a while. I guess other things came before that. During an interview on [DATE] at 11:30 AM, when the Pharmacy Consultant was asked if a resident had 180 tablets of a controlled narcotic in the medication cart, would that amount of overflow be checked for accuracy compared to the date of delivery, the Pharmacy Consultant stated, I look at the charting and see what they are working from, which sheet [Narcotic sheet] they are charting on. I wouldn't do a follow through of all the overflow. I look at the sheet they are working from. During an interview with the DON on [DATE] at 12:39 PM, when asked the process for reconciling controlled Narcotic sheets when removed from the count, the DON stated, .I have a folder and the nurses would put the sheet in the folder when completed. Some of them [nurses] would turn in the whole card [medication card] in the shred box. Some would tear off the label from the top of the card [medication card] and just put it in the box. When asked when the Narcotic sheets that were removed were compared to the medications administered, the DON stated, The Unit Managers were to get the sheets from the folder . During an interview on [DATE] at 5:15 PM, when asked how the overflow of controlled narcotics delivered by the Pharmacy were reconciled, the DON stated, .I'm not sure what you are asking. All the delivery is kept in the medication cart for the elder [resident] it is ordered for. It's entered on the Substance Count Record sheet. When asked if the Substance Count Record sheet included the amount of tablets delivered and placed in the medication cart, the DON stated, No, the number of cards is tracked [not the number of tablets] from the time added until removed . During an interview with the DON on [DATE] at 11:46 AM, the DON confirmed the Oxycodone and Hydrocodone tablets for Resident #1, #2, #5, #6, #7, #8, and #9 could not be accounted for due to missing Narcotic sheets and missing medication cards that were removed from the medication cart and were not completed. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Note: The nursing home is disputing this citation.	An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on [DATE], and was validated onsite by the surveyor on [DATE] through review of staff education and sign-in sheets, observations, interviews with staff and Administration, and review of the audits conducted as follows: Identification of other elders who may be affected by the deficient practice and corrective actions that will be put in place to ensure the deficient practice does not reoccur. On [DATE] a reconciliation of controlled medications from [DATE] to [DATE] was initiated for every resident with an order for a controlled medication verifying the disposition of the controlled medications. This was performed by the DON and Regional Signature Care Consultant (SCC) and completed on [DATE]. Hall #3 was the only hall identified with controlled medications unaccounted for. Any findings of misappropriation or diversion were reported to appropriate legal and regulatory entities: Health Facilities Commission, [NAME] Tennessee (TN) Regional Office; TN Bureau of Investigations; [NAME] Police Department, Ombudsman and Adult Protective Services (APS). The DON and SCC reviewed all delivery manifests to ensure all narcotics delivered and signed in by the alleged nurse were added to the narcotic count and narcotic box on the medication cart. This audit was completed on [DATE]. Any findings of misappropriation or diversion were reported to appropriate legal and regulatory entities. On [DATE], the affected residents with a BIMS of 8 or greater were interviewed by the DON, and all stated they received their pain medications, and all denied increased pain. On [DATE], the affected resident with a BIMS of less than 8 was assessed for pain by the DON, there were no complaints or signs of increased pain. On [DATE] all residents on hall #3 were assessed for pain by the Unit Managers. No one complained of pain. Hall #3 was the only hall identified with controlled medications unaccounted for. On [DATE] a secured cabinet with 2 locks was placed in the Four Seasons Medication storage room. Overflow of controlled medications will be stored in the secured cabinet. The cabinet has 2 locks with 2 separate keys that are assigned to 2 different licensed nurses. The DON and a witness will access the controlled medications and record transactions on a medication reconciliation record. Measures put in place and systemic changes you will make to ensure that the deficient practice does not reoccur: A root cause analysis was conducted on [DATE]. It was determined that the nurse did not follow the process for removing controlled medications; obtaining a witness to verify the removal of controlled medications. This process was changed to prevent the nurses/medication technicians from removing completed medication cards or discontinued medication cards. The DON or Unit Managers (UM) will remove controlled medications from the medication cart; completed medication cards/sheets and discontinued medication cards/sheets. Beginning [DATE], education was conducted by the DON and Staff Development Coordinator (SDC) with all staff on the Abuse and Misappropriation Policy. This was completed on [DATE]. Any staff/agency staff who were not educated will be bef[TRUNCATED]

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28913 Based on policy review, medical record review, State Medical Doctor Consultant review, and interview, the facility failed to ensure 1 of 9 (Resident #2) sampled residents reviewed for medication administration was free of any significant medication errors. Resident #2's orders for Fentanyl were erroneously changed from being administered every 3 days to being administered daily. Resident #2 was administered Fentanyl patches daily on [DATE], [DATE], and [DATE] when the prescribed order was for the patch to be applied every 72 hours. The failure to apply Resident #2's Fentanyl patches as ordered had the potential to cause serious adverse outcomes, overdose, and/or death, which placed Resident #2 in Immediate Jeopardy. Immediate Jeopardy (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, harm, serious injury, impairment, or death to a resident). The Interim Administrator, the Director of Nursing, and the Regional Significant Care Coordinator were notified of the Immediate Jeopardy for F-760 on [DATE] at 1:08 PM in the Conference Room. F-760 was cited at a scope and severity of J which is Substandard Quality of Care. A partial extended survey was conducted from [DATE] through [DATE]. The Immediate Jeopardy began [DATE], continued through [DATE], and was removed on [DATE]. An acceptable Removal Plan, which removed the immediacy of the Jeopardy for F-760 was received on [DATE]. The corrective actions were validated onsite by the surveyor on [DATE] through observation, review of records, audit review, education review, and staff interviews. Noncompliance continues at F-760 at a scope and severity of D. The facility is required to submit a Plan of Correction. The findings include: (continued on next page)

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	445377	A. Building B. Wing	04/03/2024

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	1.Review of the facility's policy titled Medication Administration dated [DATE], revealed .Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices .Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration [MAR] Record. Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and MAR are different, and the container is not flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the prescriber's orders are checked for the correct dosage schedule .Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive considering the resident's age or condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to administration of the medication. If necessary, the nurse contacts the prescriber for clarification. This interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate .Verify medication is correct three (3) times before administering the medication. a. When pulling medication from the med cart b. When dose is prepared c. Before dose is administered . 2. Review of the medical record revealed Resident #2 was admitted on [DATE], with diagnoses of Rheumatoid Arthritis, Pain Unspecified, History of Chronic Viral Hepatitis C, Atrial Fibrillation, Coronary Bypass Graft, Atherosclerotic Heart Disease, and Type 2 Diabetes. Resident #2 was scheduled to be discharged home on [DATE], but expired in the facility on [DATE]. Review of the admission Minimum Data Set assessment dated [DATE], revealed Resident #2 had a Brief Interview for Mental Status score of 15, which indicated no cognitive impairment. Review of a Physician's order for Resident #2 with a start date of [DATE], revealed an order for Fentanyl Schedule II 50 microgram (mcg) transdermal patch apply once daily every 72 hours (3 days). Review of a Physician's order for Resident #2 with a start date of [DATE], revealed Fentanyl Schedule II 75 mcg transdermal patch apply once daily every 72 hours (3 days). The 50 mcg patch was to be discontinued when the Fentanyl 75 mcg patch arrived. Review of the Medication Administration Record (MAR) dated [DATE] - [DATE], revealed a Fentanyl 50 mcg patch was applied to Resident #2 on [DATE]. The MAR documented a Fentanyl 75 mcg patch was applied to Resident #2 on [DATE] and [DATE]. Resident #2 had a Fentanyl patch applied daily for 3 days ([DATE], [DATE], and [DATE]). Review of a Nurse Practitioner (NP) Progress Note dated [DATE], revealed Rheumatoid Arthritis and Pain . Discontinue Fentanyl 50mcg and start Fentanyl 75 mcg Q [symbol for every] 72 hours . (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The State Medical Doctor Consultant Review of Resident #2's medical records dated [DATE], revealed . [Resident #2] was started on Fentanyl 25mcg/hr [hour] q72hrs on ,d+[DATE] [[DATE]], changed to Fentanyl 50 mcg/hr q 72hrs on ,d+[DATE] [[DATE]] (during this time there is some discrepancy in documentation seemingly indicating [Named Resident #2's initials] may have had his patches changed more frequently than q 72hrs) .The Progress Notes indicate that on ,d+[DATE] [[DATE]] Fentanyl 75 mcg/hr q72hrs was ordered by [Named Nurse Practitioner]. The DC [discontinued] order for the 50 mcg/ hr patch was written on , d+[DATE] [[DATE]] which could lead to confusion regarding which strength the patient was to receive-50, 75, or 125 (combination of the two) between ,d+[DATE] ad ,d+[DATE] [2024]. There is a note from [Named LPN A] indicating that the 50mcg patch was dc'd [discontinued] on ,d+[DATE] [2024] .There is a note on , d+[DATE] [[DATE]] (page 8) indicating no complications are noted with increase in Fentanyl patch dosing. Finally, notes written on ,d+[DATE] [2024] (less than 48 hours later) indicate that the patient was scheduled to be discharged after having been seen by the physician the previous day. After showering in the morning of ,d+[DATE] (the note is timed for midnight so it is not clear what time this occurred) [Named Resident #2's initials] was found unresponsive at 0942 [9:42 AM], [Named Nurse Practitioner] was contacted, there was an order to remove the Fentanyl patch at 1046 [10:46 AM] and dispose of it then an order for the patch to be replaced at 1456 [2:56 PM] prior to being pronounced dead at 1520 [3:20 PM]. [Progress notes page 8, 6, 3, 1] MD orders indicate that between ,d+[DATE]-26 [2024] Fentanyl patch 75mcg/ hr QD [every day] was ordered (dc 50mcg when 75 arrives). On ,d+[DATE]-29 [2024] the order was then changed to Fentanyl 75mcg/hr q 72hrs (dc 50 when 75 arrives). [Medical Doctor (MD) Orders Vaccines 11, 4, 6, 14] Per the MAR [Medication Administration Record] which is a bit difficult to follow due to many late entries, [Named Resident #2's initials] received (on a page with the following order)-Fentanyl 75mcg/hr q72hrs-a new patch each day on ,d+[DATE] and ,d+[DATE] [2024], no patch administered on ,d+[DATE] and ,d+[DATE] then given again on ,d+[DATE]. There is a note regarding late administration of the patch on ,d+[DATE] [2024] though it refers to the patient [Resident #2] passing after the patch was opened.[MARS page 20, ,d+[DATE], 32] Death certificate indicates cause of death as CVA [Cerebral Vascular Accident], PAD [Peripheral Arterial Disease], HTN [Hypertension]. No autopsy means unable to confirm death by Fentanyl intoxication. Based on an NIH [National Institutes of Health] article regarding Fentanyl Transdermal use, within ,d+[DATE] hours after administration the drug can be detected in the blood stream and within ,d+[DATE] hours can reach therapeutic levels. Generally it takes ,d+[DATE] hours after patch placement for drug levels to stabilize whenever starting or changing dose. Transdermal use increased bioavailability [the ability of a drug or other substance to be absorbed and used by the body] of the drug by 90% [percent] making it possible to lower the dose necessary to achieve an adequate patient response. Elimination ,d+[DATE] [half] life [the length of time required for the concentration of a drug to decrease to one-half of it's starting dose] after patch removal is ,d+[DATE] hours due to slow release of Fentanyl from the skin depot. Fully used patches contain up to 84% of the original dose within the adhesive gel. [ncbi.nlm.nih.gov] Conclusions: [Initials of Resident #2's name] died after receiving Fentanyl patches daily rather than q72 hrs as ordered. This inappropriate administration could have caused drug overdose by increasing the available drug in the bloodstream and inhibiting the elimination of that drug in the manner expected by using the patch appropriately. The notations made do however make interpretation of the actions of the staff difficult. Finally, the death certificate indicates that the patient died from CVA [Cerebral Vascular Accident] whose signs can mimic that of opioid intoxication. There was no toxicology information provided with this case so it is impossible to know the exact cause of death . (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview with the Director of Nursing (DON) on [DATE] at 2:10 PM, when asked about the Fentanyl patch being removed and reapplied on Resident #2 on [DATE], the DON stated, .The NP gave order to remove Fentanyl patch due to his [Resident #2] decline. We wanted him comfortable, so the NP gave order to reapply at same dosage [75 mcg]. Before the nurse had gotten to him he had passed . During an interview with the NP on [DATE] at 10:20 AM, the NP was asked about Resident #2 on [DATE] when he was found unresponsive. The NP stated, .They [facility staff] found him not responding. They told me and I got up from my office and went. When I saw him I knew he was initially dying. He had transitioned. I had not seen him that morning before that. I had planned to go see him before he discharged home that day . I didn't leave the room .I was assessing him. He was placid, they got vital signs. When I first walked in the room I asked does he only have one patch on? I wanted to make sure they had not left one on in error. I told them to take the patch off. [Named LPN H] took it off. After it was off I realized it wasn't the patch. He didn't come around, nothing improved. So after [that] we got a hold of the family and they were on their way. His daughter had come up and was in the room. I was talking with the daughter and because he did take pain med and had pain daily I told her we can give him oxycodone and crush it and put it in his cheek. They did that and they told me he had vomited. I then said they could put the patch back on. That's what they did . From what I've read the medicine starts immediately but doesn't reach full dose till sometime within 24 hrs. Some release at first but not full until the 24 hours time frame. The NP was asked if there were any concerns regarding the daily administration of the fentanyl patches. The NP stated, My first concern as a nurse I would have been like daily. Isn't this an every 3 day. I would think the nurse that verifies the order in matrix would have questioned a daily order. But as I've looked into the use of the patches from what I've read I would think he wasn't getting enough because of the timeframe of release. I would have been more concerned if he had 2 patches, multiple patches on. During an interview with the DON on [DATE] at 12:04 PM, when asked what a nurse should do before administering a medication, the DON stated, Have the MAR, verify the rights, verify the med [medication] is correct . During an interview on [DATE] at 10:20 AM, when the NP was asked if she had ordered a Fentanyl patch to be applied daily for Resident #2, the NP stated, .The intention was to increase the Fentanyl to 75 mcg. I put the order in Matrix [software system used for documentation in medical record], as once a day is how it turned out. I'm not sure why it came through on Matrix that way. I know I wrote it for every 3 days. The intention was for it to be every 3 days. It showed up to pharmacy as every 3 days. If it had not, they would have caught it and not accepted .I put it in my company's electronic health record to send to pharmacy. So the actual script was for every 3 days .I would think the nurse that verifies the order in Matrix would have questioned a daily order .On the box the label would have said every 3 days. Should be checking the label as well . My order to pharmacy was correct . During an interview on [DATE] at 1:45 PM, when asked if she questioned the Fentanyl 75 mcg patch to apply daily order for Resident #2, LPN J stated, I did. It crossed my mind because I knew it was every 3 days. I went ahead and verified in the computer. I should have clarified the order . During an interview on [DATE] at 11:23 AM, when asked if he applied the daily Fentanyl 75 mcg patch on Resident #2, LPN I stated, I saw the order. I thought that was strange. I had the thought that is weird. In my error I didn't call the NP or the DON to clarify. I saw that it might be wrong. I failed to look at the label. I just looked at the MAR . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445377	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Erin	278 Rocky Hollow Road Erin, TN 37061

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on [DATE], and was validated onsite by the surveyor on [DATE] through review of staff education and sign-in sheets, observations, interviews with staff and Administration, and review of the audits conducted as follows: Identification of other residents having the potential to be affected was accomplished by: On [DATE] a Medical Record review was conducted by the Director of Nursing to identify residents who have active orders for Fentanyl Transdermal patches to ensure the order was transcribed correctly. One other resident has an order for a Fentanyl Transdermal Patch. The order was correct. There were 2 residents in the facility with orders for Fentanyl Transdermal Patches and both resided on Hall #3. Findings were reported to the legal and regulatory authorities: Health Facilities Commission, [NAME] Tennessee (TN) Regional Office; Ombudsman and Adult protective Services (APS). On [DATE] an audit of medications in the medication carts was conducted by the Clinical Interdisciplinary Team (IDT) to ensure the labels on the medication cards match the order in Matrix Care. A label was placed on the cards that did not match informing to nurse there was a change in the order and to check the order in Matrix Care. This audit was completed on [DATE]. Measures/Systematic changes that will be put into place to ensure that the deficiency does not recur: A root cause analysis was conducted by the Clinical Interdisciplinary Team on [DATE]. It was determined the order had been entered for Fentanyl Transdermal Patches into MatrixCare to be applied daily instead of every 3 days. The NP entered the electronic script (e-script), which goes to the pharmacy, to be applied every 3 days. The Unit manager (UM) verified the order in MatrixCare without clarification of the order. Root cause is the need of more education regarding order entry. On [DATE] the Nurse Practitioner was educated by the Signature State Care Consultant and the Director of Nursing on Order Entry in Matrix Care. A power point and screen shots were provided. On [DATE] the Nurse Practitioner attended an on-line Matrix Care Provider Training. On [DATE] the Director of Nursing educated the Unit Manager #2 to ensure the order is transcribed accurately and clarify any discrepancies with the provider before verifying the order. On [DATE] Unit Managers #1, #2, and #3 and licensed nurses were educated to verify orders for accuracy before activating them and to clarify any discrepancies with the providers. Beginning [DATE] all licensed staff were educated by the Director of Nursing to ensure the label on the medication card matches the medication order in MatrixCare and to call the provider to clarify any discrepancies. This education was completed on [DATE]. Any staff/agency staff not educated will be prior to working their next shift. Quality Assurance & Process Improvement Program (QAPI) (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	An Ad Hoc [meeting held for a particular purpose] QAPI was held on [DATE] and [DATE] with the Leadership Team and Medical Director to discuss the incident, the investigation outcome and discuss the Plan of Correction. Beginning [DATE] the DON or Unit Manager will verify the medication card labels match the order in Matrix Care for 5 days per week for 1 week then, 3 times per week for 3 weeks then, 1 time per week for 1 month. Beginning the week of [DATE] a pharmacy nurse consultant will audit all medication carts to ensure the labels on the medication cards match the order in MatrixCare until the QAPI team determines compliance. Findings of audits will be reported to the QAPI Committee which consists of the Administrator, Director of Nursing, Unit Managers, Staff Development Coordinator, Social Services Director, Maintenance Director, Dietary Manager, Life Enrichment Director, Rehab Manager, and Medical Director. The Quality Assurance Committee will review staff education and audit logs for completion and accuracy. QAPI meetings will be held weekly beginning [DATE] for 4 weeks, then 2 times per month for the next 30 days, then monthly thereafter until the QAPI Committee determines substantial compliance. Regional oversite has been in place daily since [DATE], the date Misappropriation of Resident Property was reported to Health Facilities Commission regarding Transdermal Fentanyl Patches. The Senior (Sr.) Signature State Care Consultant has been in the facility assisting with interviews, audits, education, process changes, attending QAPI meetings, and oversight of compliance with process changes. Regional oversite has occurred onsite or by phone from the Sr. State Signature Care Consultant, the Regional [NAME] President of Clinical Operations, or the Regional [NAME] President of Operations. The Regional team has collaborated with the facility team on process changes and attended Ad HOC QAPI meetings via phone to discuss audit findings and develop a plan of correction.