STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37532 Based on facility policy review, personnel file review, medical record review, facility document review, Law Enforcement Investigation review, hospital order review, and interview, the facility failed to ensure the residents' rights to be free from misappropriation of residents' property for 13 of 13 (Resident #13, #14, #15, #18, #19, #20, #21, #22, #23, #25, #26, #28, and #30) sampled residents reviewed for misappropriation of resident property by means of diversion of resident medications including, but not limited to, controlled substances from [DATE] through [DATE]. On [DATE] facility Licensed Practical Nurse (LPN) M was arrested for drug diversion of the 13 residents' medications and controlled substances. The findings include: 1. Review of the facility policy titled, Abuse Prevention Policy with a facility review date of [DATE], revealed . The resident has the right to be free from .misappropriation of property .Facility has a zero-tolerance Abuse Standard regarding all proven allegations of .Misappropriation of Resident Property .means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent .Administrator will review investigational findings to determine appropriate corrective, remedial, or disciplinary actions to occur with accordance with applicable local, state or federal law. Administrator will review outcome in monthly continuous quality Improvement meeting. Department Manager(s) will be notified of investigation outcome for appropriate follow up and monitoring. Review of the facility policy titled, Controlled Substances revised ,d+[DATE], .The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications .Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on premises .The charge nurse on duty maintains the keys to controlled substance containers. The director of nursing services maintains a set of back-up keys for all medication storage areas including keys to controlled substance containers .Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift .Upon disposition .Medications returned to the pharmacy are recorded and signed by the director of nursing (or designee) and the receiving pharmacy . Policies and procedures for monitoring controlled medication to prevent loss, diversion .are periodically reviewed and updated by the director of nursing services and the consultant pharmacist . 2. Review of LPN M's personnel file revealed she worked in the facility from [DATE] through [DATE]. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. On [DATE], LPN M was arrested for drug diversion of residents' medications. Review of Law Enforcement's investigation revealed Investigator #1 initiated a traffic stop of LPN M on [DATE] due to a potential window tint violation. Investigator #1 observed miscellaneous pills on the driver's side floorboard. The vehicle was searched and different kinds of scheduled and non-scheduled prescription medication pill blister packs (cards of medication that the medication can be pushed through the back of the card to dispense to residents) containing names of different people were observed. LPN M informed Investigator #1 that she worked at (Named the facility). Investigator #1 discovered prescription blister packs that dated back to 2020. Investigator #1 also found a green cloth bag in the car that contained over 15 small plastic baggies containing non-scheduled and scheduled prescription drugs all packaged separately, and . the schedule drugs ranged from Schedule II from Morphine and Hydrocodone, Schedule IV Lorazepam to Xanax and Schedule V Gabapentin and Pregabalin . LPN M was taken into custody at that time and charged with Unlawful Window Tint, Unlawful Possession without Prescription, and Possess Controlled Substance with Intent to Manufacture, Deliver, or Sell Controlled Substance for Schedule II (3 counts), Schedule IV (4 counts), and Schedule V (3 counts) drugs. Continued review of Law Enforcement's investigation revealed on [DATE] a search warrant was executed at LPN M's home. Investigators located multiple different kinds of pill blister packs containing names of different people. The Schedule drugs ranged from Schedule II Morphine and Hydrocodone, Schedule IV Lorazepam and Xanax, and Schedule V Gabapentin and Pregabalin and other non-scheduled drugs in various locations in the home. LPN M was additionally charged with Unlawful Possession without Prescription, and Possess Controlled Substance with Intent to Manufacture, Deliver, or Sell Controlled Substance for Schedule II (2 counts), IV (4 counts), and V (3 counts) drugs. Review of the pictures from the Law Enforcement's investigation and search of LPN M's car and home revealed the LPN was in possession of the following Residents' medications: 3a. One (1) of Resident #13's empty muscle relaxer blister pill packs. Four (4) of Resident #14's empty controlled substance blister pill packs. Three (3) of Resident #15's empty controlled substance blister pill packs. One (1) of Resident #18's empty controlled substance blister pill packs. One (1) of Resident #19's empty controlled substance blister pill packs. Two (2) of Resident #20's empty controlled substance blister pill packs. One (1) of Resident #21's empty controlled substance blister pill packs. One (1) of Resident #22's empty controlled substance blister pill packs. One (1) of Resident #23's empty controlled substance blister pill packs. Three (3) of Resident #25's empty controlled substance blister pill packs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	One (1) of Resident #26's empty controlled substance blister pill packs. One (1) of Resident #28's empty antibiotic blister pill pack and 1 of Resident #28's empty blister pill packs. One (1) of Resident #30's empty controlled substance blister pill packs. 3b. One (1) of Resident #14's 60-count blister pill pack of Gabapentin 100 milligrams (mg) with 39 capsules remaining. One (1) of Resident #15's 45-count blister pill pack of Gabapentin 100 mg with 45 remaining. One (1) of Resident #19's 12-count blister pill pack of Hydrocodone-Acetaminophen ,d+[DATE] mg with 5 tablets remaining. One (1) of Resident #20's 60-count blister pack of Gabapentin 600 mg with 50 tablets remaining. One (1) of Resident #25's 30-count blister pack of Gabapentin 300 mg with 2 capsules remaining. One (1) of Resident #28's 14-count blister pack of Doxycycline 500 mg with 9 capsules remaining. One (1) of Resident #28's 60-count blister pack of Tramadol 50 mg with 50 tablets remaining. On [DATE], the surveyor met with Investigator #1 at the Sheriff's Department, and he provided a flash drive with over 400 pictures from the Law Enforcement investigation and a folder which contained their investigation and pictures of pill blister packs of several residents, pictures of vials of medication, and Controlled Drug Record forms that were found in the possession of LPN M. The Law Enforcement investigation revealed the following items were found in the search of LPN M's car and home: a. Schedule II-67 pills and 6 bottles of liquid. b. Schedule IV-266 pills and 2 bottles of liquid. c. Schedule V-130 pills. d. There were 704.5 total pills found in LPN M's car. e. There were 1,225 total pills found in LPN M's home. f. The total number of pills seized by law enforcement was 1,929.5. 4. Review of the medical records revealed Resident #13 was admitted to the facility on [DATE], with diagnoses including Diabetes, Dependence on Renal Dialysis, Hypothyroidism, Anxiety, Bipolar Disorder, and Insomnia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the significant change Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #13 scored a 15 on the Brief Interview for Mental Status (BIMS), which indicated Resident #13 was cognitively intact, and received antipsychotic, antianxiety, antidepressant and opioid medications. Review of the physician orders for Resident #13 dated [DATE], revealed Tizanidine Hydrochloride (HCL) (a muscle relaxer, non-scheduled medication) 2 mg, give 1 tablet by mouth four times a day. Review of the Medication Administration Record (MAR) dated [DATE] through [DATE], for Resident #13 revealed Tizanidine HCL 2 mg four times a day was discontinued on [DATE]. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1611) of Resident #13's blister pill pack of Tizanidine HCL 2 mg with a date issued of [DATE]. There were zero (0) of 60 Tizanidine tablets remaining in the blister pack. Continued review revealed a printed picture in the investigation of Resident #13's blister pill pack for Tizanidine HCL 2 mg, card 2 of 4, date issued [DATE]. There were 7 of 60 Tizanidine tablets remaining in the blister pack. Review of the quarterly MDS assessment dated [DATE], revealed Resident #13 scored a 15 on the BIMS score, which indicated Resident #13 was cognitively intact, and received antipsychotic, antianxiety, antidepressant and opioid medications. Observation and interview on [DATE] at 9:20 AM, revealed Resident #13 laying in bed, oxygen was being administered at 3 liters per minute by nasal cannula, and a grab bar was present on the left side of the bed. Resident #13 confirmed that she received scheduled medications for pain. Resident #13 stated, I remember a time or two when [Named LPN M] didn ' t give me [my] night meds .she's no longer here .for stealing drugs . I saw it on the news .Resident #13 confirmed that she reported the incident to another staff nurse . 5. Review of the closed medical record revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including Dementia, Diabetes, Osteoporosis, Insomnia, and Anxiety. Review of the quarterly MDS assessment dated [DATE], revealed Resident #14 scored a 01 on the BIMS score, which indicated Resident #14 was severely cognitively impaired, and received antianxiety, antidepressant and opioid medications. Review of the physician orders for Resident #14 dated [DATE], revealed Ativan (Lorazepam - a medication for anxiety) 0.5 mg every 12 hours as needed (PRN) for anxiety and agitation. Review of the physician orders for Resident #14 dated [DATE], revealed Percocet (Oxycodone-Acetaminophen medication for pain) ,d+[DATE] mg give 1 tablet by mouth two times a day every 6 hours as needed for pain and give 1 tablet by mouth two times a day for pain. Review of the physician orders for Resident #14 dated [DATE], revealed Gabapentin (medication for seizures and nerve pain) 100 mg give 1 capsule by mouth two times a day for diabetic neuropathy. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed pictures (#1620 and #1705) of Resident #14's blister pill pack of Lorazepam 0.5 mg, a Schedule IV controlled substance with an issue date of [DATE]. There were 0 of 50 Lorazepam tablets remaining in the blister pack. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1678) of Resident #14's blister pill pack of Oxycodone-Acetaminophen ,d+[DATE] mg, a Schedule II controlled substance, date issued [DATE]. There were 0 of 60 Percocet tablets remaining in the blister pack. Review of the Pharmacy Electronic Shipping Manifest dated [DATE] at 2:16 PM, revealed 120 Oxycodone , d+[DATE] mg tablets were delivered to the facility for Resident #14. The Manifest is the list of medications delivered to the facility from the pharmacy. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1539) of Resident #14's blister pill pack of Oxycodone-Acetaminophen ,d+[DATE] mg a Schedule II controlled substance with a date issued of [DATE]. There were 0 of 60 Percocet tablets remaining in the blister pack. Review of the Pharmacy Electronic Shipping Manifest dated [DATE] at 7:26 PM, revealed 90 Oxycodone , d+[DATE] mg were delivered to the facility for Resident #14. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1708) of Resident #14's blister pill pack of Gabapentin 100 mg, a Schedule V controlled substance, with an issued date of [DATE]. There were 39 of 60 Gabapentin capsules remaining in the blister pack. The facility was unable to provide the Pharmacy Electronic Shipping Manifest for Resident #14's Gabapentin dated [DATE] or a Controlled Drug Record form for the Lorazepam dated [DATE], the Percocet dated [DATE] and [DATE], and the Gabapentin dated [DATE]. Review of the Nurse's Note dated [DATE], revealed Resident #14 expired in the facility. 6. Review of the closed medical record revealed Resident #15 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes, Bipolar Disease, Anxiety and Insomnia. Review of the physician orders for Resident #15 dated [DATE], revealed the following: (a). Gabapentin 100 mg, give 1 capsule by mouth three times a day for neuropathy (weakness, numbness, and pain from nerve damage and pain). (b). Diazepam 5 mg, give 1 tablet by mouth every 12 hours as needed for anxiety for 14 days. (c). Hydrocodone-Acetaminophen ,d+[DATE] mg, give 1 tablet by mouth every 6 hours as needed for pain for 14 days. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1623) of Resident #15's blister pill pack of Hydrocodone-Acetaminophen ,d+[DATE] mg, a Schedule II controlled substance, with an issued date of [DATE]. There were 0 of 12 Hydrocodone-Acetaminophen tablets remaining in the blister pack. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1657) of Resident #15's blister pill pack of Diazepam 5 mg, a Schedule IV controlled substance, with an issued date of [DATE]. There were 0 of 12 Diazepam tablets remaining in the blister pack. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1659) of Resident #15's blister pill pack of Gabapentin 100 mg, a Schedule V controlled substance, with an issued date of [DATE]. There were 45 of 45 Gabapentin capsules remaining in the blister pack. Review of the 5-day MDS assessment dated [DATE], revealed Resident #15 received antipsychotic and opioid medications. The facility was unable to provide a Pharmacy Electronic Shipping Manifest to show delivery of Resident #15's Gabapentin, Diazepam, and Hydrocodone-Acetaminophen dated [DATE], or a Controlled Drug Record for Gabapentin, Diazepam, and Hydrocodone-Acetaminophen. Review of the Nurses Note dated [DATE], revealed Resident #15 left the facility against medical advice. 7. Review of the closed medical record revealed Resident #18 was admitted to the facility on [DATE], with diagnoses including Diabetes, Chronic Pain Syndrome, and Anxiety. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1693) of Resident #18's blister pill pack of Alprazolam 0.25 mg, a Schedule IV controlled substance, with an issued date of [DATE]. There were 0 of 60 remaining in the blister pack. Review of the physician orders for Resident #18 dated [DATE], revealed Alprazolam (medication used to treat anxiety/depression) 0.5 mg, give 1 tablet by mouth three times a day. The facility was unable to provide a Pharmacy Electronic Shipping Manifest to show delivery of Resident #18's Alprazolam dated [DATE], or a Controlled Drug Record form for the Alprazolam. Review of the admission MDS assessment dated [DATE], revealed Resident #18 scored a 15 on the BIMS, which indicated the Resident was cognitively intact, and received antianxiety, antidepressant, and opioid medications. Review of the Nurse's Note dated [DATE], revealed Resident #18 was discharged home. 8. Review of the closed medical record revealed Resident #19 was admitted to the facility on [DATE], with diagnoses including Prosthesis, Depression, Osteoarthritis, and Anxiety. Review of the physician orders from the Rehab Hospital for Resident #19 dated [DATE], revealed Norco 7XXX,d+[DATE] mg (Hydrocodone), give 1 tablet every 6 hours as needed for pain (pain scale ,d+[DATE]). Review of the Resident #1's admission MDS assessment dated [DATE], revealed the Resident scored a 15 on the BIMS, which indicated the Resident was cognitively intact, and received antianxiety, antidepressant, and opioid medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1391) of Resident #19' s blister pill pack of Hydrocodone-Acetaminophen 7XXX,d+[DATE] mg, a Schedule II controlled substance, date issued not visible. There were 4 of 12 Hydrocodone-Acetaminophen tablets remaining in the blister pack. The facility was unable to provide a Pharmacy Electronic Shipping Manifest to show delivery of Resident #19' s Hydrocodone-Acetaminophen or a Controlled Drug Record for the Hydrocodone-Acetaminophen. Review of the Nurse's Note dated [DATE], revealed Resident #19 was discharged home. 9. Review of the closed medical record revealed Resident #20 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Sepsis, Diabetes, Hypothyroidism, Anxiety, Insomnia. Review of the physician's order for Resident #20 dated [DATE], revealed Gabapentin 300 mg, give 2 capsules by mouth three times a day for neuropathy. Review of the physician's order for Resident #20 dated [DATE] revealed, Gabapentin 100 MG, give 1 capsule by mouth three times a day. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1655) of Resident #20's Gabapentin 600 mg, a Schedule V controlled substance, card 1 of 6, dated [DATE]. There were 0 of 30 Gabapentin capsules remaining in the blister pack. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1719) of Resident #20 ' s Gabapentin 600 mg, a Schedule V controlled substance, card 2 of 6, dated [DATE]. 50 of 60 Gabapentin capsules remained in the blister pack. The facility was unable to provide a Pharmacy Electronic Shipping Manifest to show delivery of Resident #20's Gabapentin dated [DATE] or a Controlled Substance Record for the Gabapentin. Review of the admission MDS assessment dated [DATE], revealed Resident #20 scored a 15 on the BIMS, which indicated she was cognitively intact, and received antipsychotic, antianxiety, antidepressant and opioid medications. Review of the Nurse's Note dated [DATE], revealed Resident #20 was discharged home. 10. Review of the closed medical record revealed Resident #21 was admitted to the facility on [DATE], with diagnoses including Anxiety, Chronic Obstructive, Depression and Muscle Weakness. Review of the admission MDS assessment dated [DATE], revealed Resident #21 had a BIMS score of 15, which indicated Resident #21 was cognitively intact, received anxiety, antidepressant and opioid medications. Review of the physician orders for Resident #21 dated [DATE], revealed Lorazepam 0.5 mg, give 1 tablet by mouth every 8 hours as needed for anxiety for 14 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1590) of Resident #21's blister pack for Lorazepam 0.5 mg, a Schedule IV controlled substance, issued [DATE]. There were 0 of 20 Lorazepam tablets remaining in the blister pack. The facility was unable to provide a Pharmacy Electronic Shipping Manifest to show delivery of Resident #21's Lorazepam dated [DATE] or a Controlled Drug Record form for the Lorazepam. Review of the Nurse's Note dated [DATE], revealed Resident #21 was transferred to the hospital, the resident did not return to the facility. 11. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Diabetes, Dementia, Anxiety, and Chronic Kidney Disease Stage 4. Review of the physician orders for Resident #22 dated [DATE], revealed Clonazepam 0.5 mg, give 1 tablet by mouth every 24 hours for anxiety. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1625) of Resident #22's blister pack for Clonazepam 0.5 mg, a Schedule IV controlled substance, issued [DATE]. There were 0 of 14 Clonazepam tablets remaining in the blister pack. The facility was unable to provide a Pharmacy Electronic Shipping Manifest to show delivery of Resident #22's Clonazepam dated [DATE] or a Controlled Drug Record form for the Clonazepam. Review of the quarterly MDS assessment dated [DATE], revealed Resident #22 scored a 03 on the BIMS, which indicated Resident #22 was severely cognitively impaired, and received antidepressant and opioid medications. Observation in the resident's room on [DATE] 1:25 PM, revealed a sign for contact precautions on the hall wall to the right of the door, Resident #22 lay in bed on her back, her eyes were closed, and she appeared to be asleep. The call light was in reach and the bed in low position. 12. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE], with diagnoses including Acquired Absence of Right Leg Above Knee (above the knee amputation), Anxiety, Personal History of Malignant Neoplasm of Uterus, and Diabetes. Review of the admission MDS assessment dated [DATE], revealed Resident #23 scored a 14 on the BIMS, which indicated Resident #23 was cognitively intact, and received opioids medications. Review of the physician orders dated [DATE], revealed Ativan (Lorazepam medication given for anxiety) 0.5 mg, give 1 tablet by mouth 3 times every week every Monday, Wednesday, and Friday for anxiety disorder. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1711) of Resident #23 ' s blister pack for Lorazepam 0.5 mg, a Schedule IV controlled substance, issued [DATE]. 0 of 12 Lorazepam tablets remained in the blister pack. The facility was unable to provide a Pharmacy Electronic Shipping Manifest to show delivery of Resident #23's Lorazepam dated [DATE] or a Controlled Drug Record form for the Lorazepam. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	13. Review of the closed medical records revealed Resident #25 was admitted to the facility on [DATE], with diagnoses including Diabetes, Cirrhosis of Liver, Anxiety, Insomnia, and Gout. Review of the admission MDS assessment dated [DATE] revealed Resident #25 scored a 13 on the BIMS, which indicated Resident #25 was cognitively intact, and received antidepressant medications. Review of the physician orders for Resident #25 dated [DATE], revealed Gabapentin 300 mg, give 1 capsule by mouth two times a day for seizures. Review of the MAR dated [DATE]-[DATE], revealed Resident #25 received 20 doses of Gabapentin 300 mg. Review of the Law Enforcement investigation revealed a Controlled Drug Record for Resident #25's Gabapentin 300 mg that was seized in the search of LPN M's car and home. The form revealed there should have been 2 Gabapentin on the pill blister pack that LPN M diverted from the facility. Review of the Law Enforcement investigation for the drug diversion by LPN M, revealed a picture (#1694) of Resident #25's blister pack for Gabapentin 300 mg, a Schedule IV controlled substance, issued [DATE]. 2 of 30 Gabapentin capsules remained in the blister pack. Review of the Pharmacy Electronic Shipping Manifest dated [DATE], revealed 30 Gabapentin 300 mg and 28 Lorazepam 0.5 mg were delivered for Resident #25. Review of the Medication Administration Record (MAR) for Resident #25 dated [DATE]-[DATE], revealed Alprazolam 0.5 mg, give 1 tablet every 12 hours as needed for anxiety for 14 days, was ordered on [DATE]. Resident #25 received 1 dose of Alprazolam on [DATE] at 11:31 AM. On [DATE], the frequency of the order was changed to give 1 tablet of Alprazolam every 8 hours as needed for anxiety for 14 days. Resident #25 received 1 dose of Alprazolam on [DATE] at 9:00 PM. Review of the physician's order for Resident #25 dated [DATE], revealed Alprazolam 0.5 mg, give 1 tablet by mouth every 8 hours as needed for anxious behavior. Review of the Law Enforcement investigation revealed a Controlled Drug Record form for Resident #25's Alprazolam 0.5 mg dated [DATE], that was seized in the search of LPN M's car and home. The form revealed there should have been 8 of 28 Lorazepam 0.5 mg on the pill blister pack that LPN M diverted from the facility. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1645) of Resident #25's s blister pack for Alprazolam 0.5 mg, a Schedule IV controlled substance, issued [DATE]. 0 of 28 Lorazepam tablets remained in the blister pack. Continued review of the Law Enforcement investigation revealed a Controlled Drug Record form for Resident #25's Alprazolam 0.5 mg dated [DATE], that was seized in the search of LPN M ' s car and home. The form revealed there should have been 42 of 42 Lorazepam 0.5 mg in the pill blister pack that LPN M diverted from the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1686) of Resident #25's blister pack for Alprazolam 0.5 mg, a Schedule IV controlled substance, issued [DATE]. 0 of 42 Lorazepam tablets remained in the blister pack. The facility was unable to provide a Controlled Drug Record form for Resident #25's Lorazepam dated [DATE] and [DATE]. Review of the Nurses' Note dated [DATE] revealed Resident #25 expired in the facility. 14. Review of the closed medical records revealed Resident #26 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Depression, Dementia, and Senile Degeneration of Brain. Review of the quarterly MDS assessment dated [DATE], revealed Resident had a BIMS score of 2, which indicated Resident #26 was severely cognitively impaired, and received antidepressant and opioid medications. Review of the physician's order For Resident #26 dated [DATE], revealed Lorazepam 0.5 mg, give 1 tablet by mouth four times a day for seizures. Review of the Pharmacy Electronic Shipping Manifest dated [DATE] at 8:43 PM, revealed 30 Lorazepam 0.5 mg tablets were delivered for Resident #26. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1519) of Resident #26's blister pack for Lorazepam 0.5 mg, a Schedule IV controlled substance, issued [DATE]. 0 of 30 Lorazepam tablets remained in the blister pack. The facility was unable to provide a Controlled Drug Record form for Resident #26 ' s Lorazepam dated [DATE]. Review of the Nurse's Note dated [DATE] at 7:13 PM, revealed Resident #26 expired in the facility. 15. Review of the medical records revealed Resident #28 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Diabetes, Cellulitis Right Lower Limb, and Cellulitis of Left Lower Limb. Resident #28 was discharged [DATE]. Review of the admission MDS assessment dated [DATE], revealed Resident scored a 13 on the BIMS, which indicated Resident # was cognitively intact, and received opioid medications. Review of the physician order for Resident #28 dated [DATE], revealed Tramadol (opioid medication given for pain) 50mg, give 1 tablet by mouth every 6 hours as needed for pain. Review of the Medication Administration Record (MAR) dated [DATE]-[DATE], revealed .DOXYCYCLINE MONO (monohydrate a non-scheduled medication given to treat bacterial infections)100 MG .Give .by mouth two times a day related to CELLULITIS OF RIGHT LOWER LIMB .CELLULITIS OF LEFT LOWER LIMB .for 3 days .Order dated XXX[DATE] . Continued review of the MAR revealed Resident #28 received 5 doses of Doxycycline. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1564) of Resident #28 ' s blister pack for Doxycycline 100mg, an antibiotic, date issued [DATE]. 9 of 14 Doxycycline remained in the blister pack. Review of the MAR for Resident #28 dated [DATE]-[DATE], revealed Resident #28 received 1 dose of Tramadol 50 mg. Review of the Pharmacy Electronic Shipping Manifest dated [DATE] at 8:25 PM, revealed 60 Tramadol Hydrochloride 50 mg tablets were delivered for Resident #28. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1561) of Resident #28's blister pack for Tramadol 50 mg, a Schedule IV controlled substance, date issued [DATE]. 50 of 60 Tramadol tablets remained in the blister pack. The facility was unable to provide a Controlled Drug Form for Resident #28's Tramadol dated [DATE]. Review of the Nurse's Note dated [DATE], revealed Resident #28 discharged home with family. 16. Review of the closed medical record revealed Resident #30 was admitted to the facility on [DATE], with diagnoses including Fracture of Left Femur, Dementia, Anxiety, and Dementia. Review of the admission MDS assessment dated [DATE], revealed Resident scored a 03 on the BIMS, which indicated Resident #30 was severely cognitively impaired, and received anticoagulant and diuretic medications. Review of the physician's order for Resident #30 dated [DATE], revealed Lorazepam 0.5 mg, give 1 tablet by mouth every 12 hours as needed for agitation and anxious behavior for 2 days. Do not give within 2 hours of scheduled Oxycodone. Review of the Pharmacy Electronic Shipping Manifest dated [DATE] at 3:18 PM, revealed 4 Lorazepam 0.5 mg tablets were delivered for Resident #30. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed a picture (#1520) of Resident #30's blister pack for Lorazepam 0.5 mg, a Schedule IV controlled substance, date issued [DATE]. 0 of 4 Lorazepam tablets remained in the blister pack. The facility was unable to provide a Controlled Drug Record of Resident #30's Lorazepam dated [DATE]. Review of the Nurse's Note dated [DATE], revealed Resident #30 was discharged home with her daughter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	17. During an interview on [DATE] at 9:55 AM, the Director of Nursing (DON) stated, .when a card [pill blister pack] is emptied it is pulled from the cart as well as the narcotic sheet and put in a basket that comes to me . when a narcotic is discontinued and still some left on the [medication (med)] cart the nurses and I pull that, we log it on a sheet, the number of pills the resident's name, what it [medication] is and it's locked into this double locked cabinet until pharmacy comes and then pharmacy and I will destroy those narcs .I use Rx Destroyer, chemical based that you dump [medications to be destroyed] in there .so much of the diversion part we don't have because they [Law Enforcement] took it. The DON was asked were they able to substantiate the nurse [LPN M] took any medications. The DON stated, Our investigation was limited with having enough paperwork .I would have to say yeah she did [divert resident's medications] .they brought in some sheets and I reviewed them .they were all deceased residents .she [LPN M] was delegated with removing narcotics from the cart .they [residents] would expire, she took the narcotic sheet and the narcotic and I don't know how she was able to do it without getting caught .I was floored, devasted and angry .there was no hint, everybody was floored there [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37532 Based on policy review, medical record review, facility investigation, observation, and interview, facility staff failed to ensure an allegation of abuse was reported to Administration immediately for 1 of 6 (Resident #1) sampled residents reviewed for allegations of abuse and neglect. The findings include: 1. Review of the facility's policy titled, ABUSE PREVENTION POLICY, revised on 3/1/2018 revealed . resident has the right to be free from verbal, sexual, physical and mental abuse .Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment .are reported immediately, but no later than 2 hours after the allegation is made . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Diabetes, Human Immunodeficiency Virus Disease, Depression, and Encephalopathy. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #1 was cognitively intact. Review of the progress notes dated 2/27/2025, revealed .This nurse and another nurse were walking down the A hall when this [Resident #1] motioned for us to come here. We entered his room and asked if he needed something he stated that someone stuck their finger in his butt last night. I asked what she looked like. [Named Resident #1] stated it was a he. I asked him if he could describe him, and he stated that he was tall and had curly hair. I asked him if he was his CNA [Certified Nursing Assistant]. He stated I guess so, I don't know. I Called the administrator immediately and reported what [Named Resident #1] had told me. Called for ambulance transport to .ER [emergency room] . During an observation and interview on 3/11/2025 at 8:59 AM, revealed Resident #1 lying in the bed with the head of the bed up approximately 45 degrees, a coffee cup on the overbed table, Quarter (1/4) side tails x 2. Resident #1 was asked are you receiving good care. Resident #1 stated, .assume they are . Resident #1 was asked if he had had ever been abused or touched inappropriately here in the facility. Resident #1 stated, Touched inappropriately. Resident #1 was very difficult to understand and communicate with. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/2025 at 3:29 PM, Certified Nursing Assistant (CNA) R was asked about the alleged incident with Resident #1. CNA R stated, .short staffed .one of our CNAs had left early on C hall, can't work it by yourself .skilled people .that needs helps, too much for one person. This night [2/26/2025] our unit manager called and asked if I could help .on C hall .asked if anyone on my hall needed help. I told her I had .[Named Resident #1] .could [Named accused CNA F] help me with my people .as we were coming out [referring to another resident's room] [Named accused CNA F] said hey [Named Resident #1] is done, he [Resident #1] was cursing 'black son of a b**** [expletive],' he [Resident #1] was like ' .he raped me.' I was like that quick [happened that quick] and he was like yeah. I said give me a second .the new nurse .was [NAME] [missing in action] .he was nowhere to be found and so I told [what Named Resident #1 had reported] the next day .I had an Uber waiting on me, so I told the next day .I'm sorry .I know you have to tell right away .now I know to tell any nurse in charge. I feel bad I tried to tell my nurse, and he wasn't there [CNA R could not find him] .on my mind the whole night . During an interview on 3/5/2025 at 1:51 PM, Registered Nurse (RN) A stated, . he [Named Resident #1] sometimes will motion to me [to come in his room], so I didn't think anything about it until he told me that [the allegation of abuse]. He's with it. He said this is hard to talk about .Me and [Named RN P] were walking down the hall from medical records. We walked by and I said, hey, I waved, he waved and he [motioned with his hand] motioned me to come in .I said what's wrong because something was off .he said, Stuck his finger in my butt and tried to screw me with it. I said who, what does she look like. He said, It wasn't a she, it was a he .tall and curly hair. We only have 1 male CNA in the building .I said okay [Named Resident #1] he stuck his finger in he said 'yes' I said I've got to go report this .reported it then started calling the Nurse Practitioner . She said send him to the hospital . RN A was asked do your recall what day he told you. RN A stated, Thursday .2/27/2025 . RN A was asked did he tell you he had told anyone else. RN A stated, No .when she [Administrator] told me to start investigating and that's when I run up on [Named CNA R] and of course [Named accused CNA F] .I did skin checks on everybody in his [CNA F] section, and I didn ' t find anything. RN A confirmed she had talked to CNA [R] and stated, .got her to write her statement and of course I did an in-service afterwards .take it serious even if they ' re [the resident] confused, just go ahead and call [Named Administrator] . RN A was asked is that when you found out he (Resident #1) reported the same thing to CNA R the night before. RN A stated, Yeah she [CNA R] was in the room next [to Named Resident #1] and heard him yelling . During an interview on 3/20/2025 at 8:59 AM, the Chief Nursing Officer confirmed when an allegation of abuse is made it should be reported immediately and stated, .we have 2 hours to report it . During a telephone interview on 3/21/2025 at 12:13 PM, the Administrator stated, .He [Resident #1] reported to nurse supervisor that a staff member tried to put his finger in his rectum .we looked at the schedule .I think he described him to us .when we did the investigation suspended him [CNA F] .when we interviewed the male CNA [F] he denied it .[Named Resident #1] said he [CNA F] didn't do it .just tried to .we sent him [Resident #1] to the ER . The Administrator confirmed when an allegation of abuse is made it should be reported immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37532 Based on policy review, medical record review, facility investigation, and interview, the facility failed to implement effective interventions and supervision to prevent falls and incidents of elopement for 2 of 5 (Resident #17 and #5) sampled residents reviewed for accidents. Resident #17 had severe cognitive impairment and was dependent upon staff for assistance with all aspects of care. On [DATE] and [DATE], Resident #17 had undocumented new behaviors of attempting to climb out of the bed, then on [DATE], Resident #17 sustained an unwitnessed fall with a head injury which resulted in actual HARM. Resident #17 was transferred to the Emergency Department (ED), and a computed tomography scan (CT Scan - a detailed x-ray to diagnose conditions) of the brain revealed a subarachnoid hemorrhage (also referred to as subarachnoid bleed, is bleeding into the area between the innermost layer of the brain's protective membranes and the layers that surround the brain) and a left lateral periorbital fracture (broken bone in the side wall of the eye socket usually resulting from blunt force trauma). On [DATE], Resident #5, a resident with severe cognitive impairment, eloped from the facility through the front door of the facility. Resident #5 was gone from the facility for approximately 12 minutes and found at approximately 12:17 PM, in the pharmacy building directly in front of the facility. Resident #5 sustained no injuries during the elopement. The findings include: 1. Review of the policy titled, Free of Accident Hazards/Supervision/Devices dated [DATE], revealed .It is the policy of the facility to ensure it provides an environment that is free from accident hazards .provides supervision .to prevent avoidable accidents. This includes: Identifying hazard(s) and risk(s); and Monitoring for effectiveness and modifying interventions when necessary. Accidents refers to any unexpected or unintentional incident, which results or may result in injury .to a resident .Avoidable Accidents .means that accidents occurred because the facility failed to .Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices; and/or .Evaluate and analyze the hazards and risks and eliminate them, or, if not possible, identify and implement measures to reduce the hazards/risks as much as possible; and/or .Implement interventions, including adequate supervision, and assistive devices, consistent with a resident's needs, goals, care plan, and current professional standards of practice in order to eliminate the risk, if possible, and if not, reduce the risk of an accident; and/or .Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice .Fall refers to unintentionally coming to rest on the ground, floor, or other lower level .Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred .Supervision/Adequate Supervision .refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the policy title, Fall Risk-Fall Prevention Assessment revised [DATE], revealed .It is the policy of the facility in conjunction with the Attending Physician, Consultant Pharmacist, Therapy Staff, Nursing Staff and others to seek to identify resident risk factors for falls .All residents .are screened for fall risk on admission, significant change of condition, quarterly, and annually. All residents .scored greater than 10 considered a high risk per fall screen will be referred to therapy and/or restorative nursing as deemed appropriate. All residents .that had a score of 10 on a fall screen will have a care plan to minimize injury from the fall .All falls, incidents, accidents will be reviewed in the Daily Clinical meeting, Monthly QAPI meeting, and Patient At Risk meetings . 2. Review of the medical record revealed Resident #17 was readmitted to the facility on [DATE], following a hospital discharge with diagnoses of Acquired absence of right leg below the knee (due to below the knee amputation on [DATE]), Dementia, and Peripheral Vascular disease. Review of the Occupational Therapy (OT) evaluation dated Saturday [DATE] at 3:05 PM, revealed Resident #17 experienced bilateral lower extremity pain at rest and with movement, described the pain as terrible and rated the pain as 10 on ,d+[DATE] scale (10 being highest pain level/severe). The OT pain evaluation revealed Resident #17 verbalized pain and indicated pain limited the resident's functional activities, the Resident experienced impaired sensation, and coordination and reported to the OT that she feels a burning sensation in her foot sometimes. The OT clinical impression revealed Resident #17 was non-weight bearing (NWB) of the right lower extremity due to a recent amputation, resulting in decreased functional mobility and coordination and was at risk for falls. Review of the Clinical Morning Meeting notes dated [DATE], revealed Resident #17 was listed as an Admission. There was no documentation in the Clinical Morning Meeting notes to address Resident #17's risk for falls or new onset of trying to climb out of the bed. Review of the Fall Risk assessment dated [DATE], revealed Resident #17 scored a 10 which indicated the Resident was at risk for falls. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #17 scored a 4 on the Brief Interview for Mental Status (BIMS) assessment, which indicated Resident #17 had severe cognitive impairment. Resident #17 required assistance from staff for all aspects of care. Review of the Baseline Care Plan dated [DATE], revealed Resident #17 required assistance with Activities of Daily Living (ADL) and was at Risk for falls. Interventions included to encourage the Resident to the use the call light for assistance, ensure appropriate footwear was worn when out of bed (OOB), and to keep items within reach. The projected outcome for these interventions was Resident #17 .will not sustain serious injury . Review of the Physical Therapy (PT) evaluation dated [DATE], revealed Resident #17 exhibited significant pain in the left lower extremity during unsuccessful attempts to stand. The PT evaluation determined the resident was at risk for falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Nursing Progress Note by Licensed Practical Nurse (LPN) B dated [DATE] at 2:20 PM, revealed .Called to [Resident #17]'s room by CNA [certified nursing assistant] .Patient [Resident #17] could not state what happened but did state that she hit her head. Patient did not have socks or shoes and patient has a new RBKA [right below the knee amputation] .Noted swelling by her left eye and a skin tear on her right hand .CNA and nurse assisted patient up and back into bed .Received new order to send patient to ER [emergency room /Emergency Department] for head CT [scan] . Review of the Hospital emergency department (ED) record dated [DATE] beginning at 4:02 PM, revealed Resident #17 arrived at the hospital by ambulance for evaluation and treatment after falling at the facility. During the ED exam, the Resident was disoriented and unable to follow simple commands. A Brain CT revealed a left lateral orbital fracture and subarachnoid hemorrhage. Review of the facility investigation dated [DATE], revealed Resident #17 was found on the floor in her room. The Resident was not wearing socks or shoes, was unable to recall what happened, and stated she hit her head when she fell . The facility investigation listed the Resident's injuries as a hematoma on the face and skin tear to right head. The mental status assessment indicated resident was alert and oriented. The facility investigation did not include documentation of Resident #17's new onset of trying to climb out of bed on [DATE] and [DATE]. There was no documentation in the progress notes regarding Resident #17 attempts to climb out of bed on [DATE] and [DATE]. During an interview on [DATE] at 10:29 AM, the Minimum Data Set (MDS) Nurse was asked what interventions were implemented to reduce the risk of falls with injury for Resident #17. The MDS nurse stated the baseline care plan interventions related to the Resident's risk for falls were to ensure appropriate footwear, keep items within reach of the Resident, and to encourage the Resident to use the call light. The MDS nurse was asked if encouraging a cognitively impaired Resident to use the call light was an appropriate intervention. The MDS nurse confirmed the Resident may not be able to retain instructions regarding use of the call light. During an interview on [DATE] at 12:12 PM, LPN G stated Resident #17 was placed in a chair at the nurses' station on Sunday [DATE], because the Resident was attempting to get out of bed. LPN G was asked if the plan of care was revised to address the Resident's attempt to get out of bed. LPN G stated, No. During an interview on [DATE] at 1:45 PM, the PT stated she conducted a physical therapy evaluation on Monday [DATE], prior to Resident #17's fall. The PT was asked to describe Resident #17's condition during the evaluation on [DATE]. The PT stated Resident #17 was very confused, in a lot of pain, and was at risk for falls. During an interview on [DATE] at 2:00 PM, CNA K stated she was assigned to Resident #17 on Saturday [DATE] and Sunday [DATE]. CNA K stated, [Resident #17] started trying to climb out of bed and seemed anxious. She wasn't like that before her leg was amputated. So, we got her up in a chair and put her at the nurses' station. During an interview on [DATE] at 2:20 PM, the Medical Director confirmed (Resident #17)'s uncontrolled pain and increased confusion were likely contributing factors to the new onset of the Resident climbing out of bed prior to falling on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 5:02 PM, Resident #17's family member stated Resident #17 was discharged home from the hospital with hospice care. Resident #17 expired on [DATE]. 3. Review of the facility policy titled, ELOPEMENT OF RESIDENT POLICY reviewed [DATE], revealed .It is the standard of this Health Care Center that appropriate procedures exist in the case of a missing resident. A missing resident is defined as a resident who has left the facility grounds without being signed out on pass . Review of the closed medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses of Urinary Tract Infection (UTI), Dementia, Hypertension, Dizziness and Giddiness, Adult Failure to Thrive, and Cognitive Communication Deficit. Review of the Clinical Admission documentation dated [DATE], revealed Resident #5 displayed short-term memory loss, spoke coherently, and exhibited no wandering behaviors on admission. Review of the Elopement Evaluation dated [DATE], revealed Resident #5 did not have a prior history of elopement or wandering behaviors and scored a 0.0 on the Elopement Evaluation, meaning the resident was not assessed to be at risk of elopement. Review of the admission MDS assessment dated [DATE], revealed Resident #5 scored a 5 on the BIMS assessment, which indicated Resident #5 had severe cognitive impairment, and exhibited wandering behaviors on 1 to 3 days of the lookback period. Resident #5 required supervision/touching assistance to partial/moderate assistance for most activities of daily living. Review of the Resident #5's admission care plan dated [DATE], revealed no documentation of interventions for elopement and wandering. Review of the facility investigation dated [DATE], revealed [DATE] around 12:22 [PM], Administrator was notified that resident [Resident #5] had exited the building and was located next door at the pharmacy .Staff stated resident was sitting at the nurse's station all morning, so when they saw she was not sitting they began to ask where she was, searched the building, called the code [code that a resident had eloped], asked the receptionist if she had seen her [Resident #5], they described the resident, she [Receptionist] stated she [Resident #5] left and stated she signed out when asked by the receptionist. Resident was located at [Named] Pharmacy .about 228 feet away. Administrator spoke with [Named Pharmacy] salesclerk, she stated the resident browsed and attempted to purchase a soda. She [the Pharmacy salesclerk] stated the resident was in there [in the Pharmacy] about 10 minutes before our staff [the facility] came in .Resident was determined to be out of the building from 12:05pm to 12:17pm . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 1:05 PM, CNA O stated Resident #5 was on her assigned hall and denied that Resident #5 exhibited any behaviors that indicated she was an elopement risk from the time she admitted on [DATE] until she eloped from the facility on [DATE]. CNA O was asked when was the last time she had seen Resident #5 before she was told the Resident was missing. CNA O stated, .In her room .11:00 or 11:30 [AM] .I believe the nurse that day .she .was looking for her [Resident #5] for medication I think, didn't find her in the room. We went around looking in every room .I looked in all the rooms, the restrooms, once we looked on C hall, B hall, and A hall we started looking outside. Once I got outside, I heard them [facility staff] yelling she [the Resident] was at [Named Pharmacy] .She [Resident #5] was very happy, seemed like she was trying to get her a drink. She didn't seem very confused .I believe we had a receptionist here, a newer lady, she said she let her out .believe she told us that when we come back in . CNA O stated they put a wander guard on Resident #5 that day. During an interview on [DATE] at 3:39 PM, the Administrator stated, I wasn't here. They called and said that she [Resident #5] had went out. The receptionist had asked [Resident #5] was she a visitor and she [the Resident] said yes, so she [the receptionist] let her out .she [the Resident] was not in the elopement book [the elopement book at the front door, in the Therapy department, and at each Nurse's Station] .she always sits at C Hall and [staff] always know where she is, noticed she was gone when they get [got] ready to pass trays, got to looking around the building .asked the receptionist, she said she let her out, she thought she was a visitor .she [the Resident] used to work here [as a CNA], she would always go to [Named Pharmacy] on break and buy a coke then bring it back and sit on the porch and drink it .asked her what she was doing [in the pharmacy] she said she was getting a Coke .brought her back, we did the wander guard, elopement assessment, put her in the book [the elopement book]. The Administrator stated, We implemented stickers [green visitor stickers] took the book [sign-in book] off of C Hall and brought it to one place .had everybody start coming in [at] one place [front door] .if they don't have the sticker they have to verify they are not a visitor before they [receptionist] let them out the door, seems to be working pretty good. The Administrator stated the pharmacy was measured to be approximately 228 feet from the facility and Resident #5 was gone 12 minutes. The Administrator stated she was able to identify the time Resident #5 eloped because she left at the same time the other visitors had left the facility. During a telephone interview on [DATE] at 9:40 AM, the Receptionist stated, Like I told the Manager [Administrator] she [Resident #5] had her purse, she wasn't in a wheelchair, she didn't have anything that could prove she was a resident. She told me she walked in and signed in on the C Hall. The Receptionist confirmed there was a sign-in sheet on the C Hall at that time. The Receptionist was asked how would you know which residents were an elopement risk. The Receptionist stated, Because they have a little binder [the elopement book] with pictures on them and I would look through it so I would recognize if they tried leaving . they didn't have a picture of her [in the binder] until the incident .they asked me to add a picture of her [[DATE]] .I was talking to this couple and they normally walk in through the main entrance and she just appeared and .was like do I have to sign out and I was like did you sign in at C Hall and she was like, yes . she was like I'm just going to get something from the store .since I didn't know all the residents at the time I didn't know some were able to walk like her . The Receptionist confirmed she had only worked in the facility 3 or 4 months at the time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0697 Level of Harm - Immediate jeopardy to resident health or safety 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** 37532 Based on policy review, medical record review, hospital record review, observation, and interview, the facility failed to provide appropriate pain management consistent with professional standards of practice for 2 of 6 (Resident # 9 and #17) residents reviewed for pain management. The facility's failure to appropriately manage pain resulted in Immediate Jeopardy (IJ) on [DATE], when Resident #17 was readmitted to the facility following a right below the knee amputation on [DATE]. Resident #17 was severely cognitively impaired and dependent upon staff for assistance with all aspects of care. Resident #17's pain level was assessed as a 5 (on a scale of 1 - 10 with 10 being the most severe) on admission. On [DATE], Resident #17's physician orders included Hydrocodone every 6 hours as needed for a moderate pain level of , d+[DATE] and Ibuprofen 800 milligrams (mg) every 8 hours as needed for a mild pain level of ,d+[DATE]. The facility failed to administer Hydrocodone as needed for pain which resulted in Resident #17 experiencing uncontrolled pain as evidence by the Resident's restlessness and trembling of the extremity. Resident #17 developed a new behavior of climbing out of bed on [DATE] and on [DATE]. Resident #17 sustained an unwitnessed fall with head injury, was transferred to the hospital and diagnosed with subarachnoid hemorrhage and a periorbital fracture. The facility failed to have a system in place to assess pain of residents with cognitive impairment and appropriately address the pain. The failure of the facility to appropriately assess, monitor, and control Resident #9's pain resulted in Immediate Jeopardy with Actual Harm for Resident #17. On [DATE] at 1:15 AM, Resident #9 sustained an unwitnessed fall. At 9:15 AM, Resident #9 began to exhibit verbal complaints and nonverbal cues of intense pain, hollering out when her right leg was moved, grimacing, and guarding her right hip and femur (thigh bone). The practitioner was not immediately notified of Resident #9's pain and the Resident did not receive pain medication. A STAT (without delay, immediate) x-ray of the femur was ordered at 11:31 AM and was obtained approximately 2 hours later at 1:32 PM. The x-ray revealed Resident #9 suffered a periprosthetic fracture (fracture that occurs around or near an orthopedic implant). Resident #9 was transferred to the hospital at approximately 3:40 PM. Review of the medical record revealed Resident #9 did not receive pain medication prior to leaving the facility. The failure of the facility to appropriately assess, monitor, and control Resident #9's pain resulted in Immediate Jeopardy with Actual Harm for Resident #9. Immediate Jeopardy (IJ) is a situation in which a 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 Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) for F-697 on [DATE] at 5:20 PM, and an amended IJ notification was provided on [DATE] at 6:47 PM, in the Administrator's office. The facility was cited Immediate Jeopardy at F-697 at a scope and severity of J which is substandard quality of care. A partial-extended survey was conducted [DATE] through [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An acceptable Removal Plan which removed the immediacy of the Jeopardy for F-697 was received on [DATE], and the Removal Plan was validated on-site by the surveyors on [DATE] through pain assessment review, medical record review, observation, review of education records, and staff interviews. The IJ began on [DATE] through [DATE] for F-697, the IJ was removed on [DATE]. The facility's noncompliance at F-697 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: 1. Review of the undated facility policy titled, Pain Management, revealed, .The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice Review of the facility policy titled, Charting and Documentation, revised ,d+[DATE], revealed .All services provided to the resident .or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . The following information is to be documented in the resident medical record .Medications administered . Treatment or services performed . 2. Review of the medical record revealed Resident #17 was readmitted to the facility on [DATE], following hospital discharge with diagnoses including Acquired absence of right leg below the knee due to a below the knee amputation on [DATE], Dementia, and Peripheral Vascular disease. Review of the hospital discharge physician orders for Resident #17 dated [DATE], revealed Hydrocodone-Acetaminophen ,d+[DATE]mg 1tablet every 4 hours as needed for pain. Review of the admission assessment dated [DATE] at 6:30 PM, revealed Resident #17 was experiencing pain rated as 5, which frequently caused difficulty sleeping and led to limitations of day-to-day activities. Review of the physician orders for Resident #17 dated [DATE] revealed the following: (a). Order date [DATE]. Start date [DATE]. Hydrocodone-Acetaminophen Oral Tablet ,d+[DATE] MG. Give 1 tablet by mouth every 6 hours as needed for MODERATE PAIN (,d+[DATE]) for PERIPHERAL VASCULAR DISEASE, UNSPECIFIED (b). Order date [DATE]. Start date [DATE]. Ibuprofen 800 MG give 1 tablet by mouth every 8 hours as needed for MILD PAIN (,d+[DATE]) for PERIPHERAL VASCULAR DISEASE. (c). Assess Pain Level and score every shift and as needed. 0 for No Pain. ,d+[DATE] for Mild Pain. , d+[DATE] for Moderate Pain. ,d+[DATE] for Excruciating Pain related to PERIPHERAL VASCULAR DISEASE. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Medication Administration Record dated [DATE] through [DATE] revealed the following: (a). On [DATE] at 7:36 PM, Licensed Practical Nurse (LPN) E administered Ibuprofen 800 MG for Resident #17's pain rated as 6. (b). On [DATE] at 6:02 AM, LPN E administered Ibuprofen 800 MG for Resident #17's pain rated as 7. (c). On [DATE] at 4:04 PM, LPN D administered Ibuprofen 800 MG for Resident #17's pain rated as 4. (d). On [DATE] at 12:54 AM, LPN E administered Ibuprofen 800 MG for Resident #17's pain rated as 7. (e). On [DATE] 9:44 AM, LPN B administered Ibuprofen 800 MG for pain rated as 7. Review of the baseline care plan dated [DATE], revealed no documentation of interventions related to pain assessment or pain management. Review of Resident #17's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief interview for Mental Status (BIMS) score of 4, indicating severe cognitive impairment. The drug regimen review indicated no concerns were identified related to significant medications. The MDS assessment dated [DATE], did not identify potentially clinically significant medication issues related to inadequate management of Resident #17's pain, as evidenced by Hydrocodone was not administered as per the physician's order for pain rated ,d+[DATE]. Review of the progress notes for Resident #17 revealed the following: (a). On [DATE] at 5:39 PM, Registered Nurse (RN) J documented that Resident #17's right below the knee amputation incision had 29 staples and a fluid filled blister was observed on the left lower extremity (LLE) and the left foot was cyanotic (bluish color from poor circulation) and cold. RN J documented a deep tissue (pressure) injury was observed on the Resident's left great toe and left heel. (b). On [DATE] at 6:27 PM, LPN D wrote, This nurse called pharmacy to see if resident hydrocodone-acetaminophen ,d+[DATE] was in transit and pharmacy said they never received a script [prescription] for this medication. (c). On [DATE] at 6:44 PM, RN F wrote, Fluid filled blister [on left lower extremity] has ruptured . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Occupational Therapy (OT) evaluation dated Saturday [DATE] at 3:05 PM, revealed Resident #17 experienced bilateral lower extremity pain at rest and with movement, described the pain as terrible and rated the pain a 10 on ,d+[DATE] scale. The OT pain assessment revealed Resident #17 verbalized pain and indicated the pain limited the Resident's functional activities, the Resident experienced impaired sensation, and coordination and reported to the OT that she felt a burning sensation in her foot sometimes. The OT documented the Resident's right lower extremity amputation site was closed with staples. The OT's clinical impression revealed Resident #17 was non-weight bearing (NWB) of the right lower extremity due to a recent below the knee amputation which resulted in the Resident's decreased functional mobility and coordination. Risk Factors identified for Resident #17 were at risk for falls. Review of Resident #17's Physical Therapy evaluation dated [DATE], revealed .significant LLE [left lower extremity] pain .hindering her mobility .attempts made at standing but pt [patient/Resident #17] with complaints of significant LLE pain and thus unable .the patient is at risk for falls . Review of the provider note dated [DATE], by Nurse Practitioner (NP) H revealed . patient [Resident #17] with pain to stump following BKA [below the knee amputation] . [Resident #17] continues to complain of pain to the R [right] BKA .The weekend staff also requested pain medication from the on-call NP .None has been sent from the pharmacy . Review of the provider note dated [DATE], by NP I revealed, . [Resident #17]'s pain is currently not controlled . Review of the nurses note dated [DATE] at 2:35 PM, by LPN B revealed, .Called to room by CNA [certified nursing assistant]. [Resident #17] was sitting on the floor with back facing the bed. Patient [Resident #17] could no [not] state what happened but did state that she hit her head. Patient did not have on any socks or shoes and patient has a new RBKA [right below the knee amputation] Noted swelling by her left eye and a skin tear on her right hand .Received new order to send patient to ER [emergency room] for head CT [computerized tomography scan - a detailed x-ray to diagnose conditions] . Review of the hospital Emergency Department (ED) records for Resident #17 dated [DATE] beginning at 4:02 PM, revealed, .presents to the ED after a fall. Patient recently had a below the knee amputation on her right leg .Not oriented, does not obey simple commands .Diagnoses Subarachnoid bleed [also referred to as subarachnoid hemorrhage, is bleeding into the area between the innermost layer of the brain's protective membranes and the layers that surround the brain] .Left lateral orbital fracture [broken bone in the side wall of the eye socket usually resulting from blunt force trauma] . During an interview on [DATE] 2:29 PM, LPN E stated she gave Resident #17 Ibuprofen because the pharmacy had not delivered the Hydrocodone. LPN E was asked why the hydrocodone wasn't delivered from the pharmacy and LPN E stated it was a common occurrence for medications not to be available until the following day. LPN E was asked how Resident #17 was assessed for pain. LPN E stated she looked for non-verbal signs of pain. During an interview on [DATE] 2:54 PM, Registered Nurse (RN) J stated she was aware on Saturday [DATE], Resident (#17) did not have Hydrocodone available for pain. RN J was asked if she, as the RN on duty, was responsible for assisting with follow up to ensure residents have appropriate pain medications available. RN J stated the nurse assigned to the resident is responsible. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] 3:24 PM, Resident #17's family member (FM) stated Resident #17 appeared to be in pain, was restless, and unable to answer questions about pain. The FM stated the nurse kept saying the Hydrocodone would probably be in the next pharmacy delivery date to the facility. FM stated Ibuprofen didn't seem to control Resident #17's pain. During an interview on [DATE] 3:32 PM, NP H stated she saw Resident #17 on [DATE], and the Resident was rubbing her leg/BKA site. NP H confirmed during interview it was reasonable to believe the Resident was in pain following the amputation despite receiving Ibuprofen 800 mg for pain. NP H confirmed Resident #17's nurse called the on-call NP on [DATE] to inquire about an order for Hydrocodone. During an interview on [DATE] 3:47 PM the facility pharmacy representative stated Resident #17's admission orders were received on [DATE], and stated no order was received for Hydrocodone for pain. The pharmacy representative stated the facility nurse was told on [DATE], an order was needed to dispense and deliver the Hydrocodone for Resident #17. During an interview on [DATE] at 9:41 AM, the Director of Nursing (DON) was asked if Ibuprofen was appropriate pain management for Resident #17 on admission following a pain assessment that revealed a new right BKA and pain rated at 5. The DON stated, No, the order states for pain rated 4 or greater, Hydrocodone should have been administered. The DON confirmed it was reasonable to believe Ibuprofen 800 mg was inadequate to control Resident #17's pain. During an interview on [DATE] 11:48 AM, LPN D stated, I didn't give [Resident #17] Hydrocodone because it wasn't delivered to the facility. I assessed her pain and rated it as a 5 based on her physical symptoms, she [the Resident] had facial grimacing and appeared to be in pain. LPN D was asked if Resident #17 should have received Hydrocodone for pain rated at 5. LPN D stated, Yes. LPN D was asked if the Emergency narcotic supply kit (E-Kit) on the medication cart contained Hydrocodone. LPN D stated, yes, but the E-Kit [Hydrocodone] was expired. LPN D confirmed Resident #17 was able to communicate and answer simple questions. LPN D was asked how Resident #17 was assessed for pain. LPN D stated she observed for nonverbal cues. During an interview on [DATE] at 12:12 PM, LPN G was asked how Resident #17 was assessed for pain. LPN G stated she assessed for nonverbal signs of pain. LPN G was asked if Resident #17 should have been receiving Hydrocodone as ordered for pain and LPN G stated, Yes, I believe [named Resident #17] should have been given Hydrocodone because the Ibuprofen was probably not enough since she'd just had an amputation a few days prior. LPN G was asked if Hydrocodone was available in the emergency narcotic kit on the medication cart. LPN G stated the nurses could not use the E-Kit because the pharmacy stated they had not received an order for Hydrocodone, and medications can only be removed from the E-kit narcotic supply box if the pharmacy has an order for the medication. LPN G stated Resident #17 was placed in a chair at the nurses' station on Sunday [DATE], because the Resident started trying to get out of bed. LPN G was asked if Resident #17 attempting to get out of bed was the result of insufficient pain management and LPN G stated she wasn't sure. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 1:45 PM, the Physical Therapist (PT) stated she conducted a physical therapy evaluation on Monday [DATE], prior to Resident #17's fall. The PT was asked to describe Resident #17's condition during the evaluation on [DATE]. The PT stated Resident #17 was very confused and in a lot of pain. The PT was asked if the Resident was able to communicate verbally about her pain. The PT stated the Resident reported having pain in the left lower leg. The PT was asked if Resident #17 had any other signs of pain. The PT stated the Resident was restless and trembled. The PT stated she reported the Resident's pain to the nursing staff. During an interview on [DATE] 2:00 PM, CNA K stated she was assigned to Resident #17 on Saturday [DATE] and Sunday [DATE]. CNA K was asked if Resident #17 had signs or symptoms of being in pain. CNA K stated the Resident complained of pain. CNA K stated she believed Resident #17's pain was getting worse as the weekend progressed. CNA K was asked how she determined Resident #17's pain was getting worse over the weekend. CNA K replied, She started trying to climb out of bed and seemed anxious. She wasn't like that before her leg was amputated. So, we got her up in a chair and put her at the nurses' station. During an interview on [DATE] 9:05 AM, the Occupational Therapist (OT) confirmed she conducted an OT evaluation of Resident #17 on Saturday [DATE]. The OT was asked to describe Resident #17's level of pain during the evaluation. The OT stated Resident #17 was having significant pain and stated Resident #17 reported her left leg was causing pain. During an interview on [DATE] at 11:00 AM, the DON was asked how the nurses should assess pain for cognitively impaired residents. The DON stated the nurses should conduct a pain assessment using a tool designed to assess residents with cognitive impairment. The DON was asked to provide surveyors with a copy of the pain assessment tool referenced. The pain assessment tool was not provided to surveyors for review. The DON was asked if nurses should document details of pain assessment findings at the time pain medication was administered. The DON stated yes, a description of the pain assessment findings would be beneficial when a follow-up assessment was conducted to determine if the signs/symptoms of pain had resolved. During an interview on [DATE] at 2:20 PM, the Medical Director confirmed Resident #17's uncontrolled pain of the lower extremities could have led to agitation and was likely a contributing factor to the new onset of the Resident climbing out of bed. The Medical Director stated he would expect the staff to follow up on why Resident #17's Hydrocodone was not available. The Medical Director added, All it would have taken was a call from one of our providers to [named pharmacy] . if they have a script [prescription] and it's [Hydrocodone] in the e-kit, they can call and get a code [to administer the hydrocodone] . The pharmacy process is flawed . 3. Review of the medical records revealed Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Dementia, Diabetes, Anxiety, Periprosthetic Fracture Around Internal Prosthetic Hip Joint, and Pain in Right Knee. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #9 was rarely understood, exhibited short-term and long-term memory problems, and was assessed by staff with severe cognitive impairment for daily decision-making skills. Resident #9 was dependent on staff for most activities of daily living (ADLs). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a physician's order for Resident #9 dated [DATE], revealed give Acetaminophen 325 mg 3 tablets by mouth two times a day. Review of the Medication Admin (Administration) Audit Report dated [DATE]-[DATE], revealed Resident #9's Acetaminophen was scheduled to be administered at 7:00 AM and 7:00 PM. Review of the undated facility document titled, Med [Medication] Pass Time Frames revealed, .two times day .7 [7:00 AM]-10A [AM] or 7 [7:00 PM]-10p [PM] for pm . Review of the Nurses' Note for Resident #9 dated [DATE] at 1:15 AM, revealed staff at the Nurse's Station heard Resident #9 yelling for help. Resident #9 was found laying on the left side of the bed on the floor in her room with her head up against the bed mattress. Resident #9 exhibited no signs or symptoms of pain at that time. The staff began neuro-checks (an exam to assess the function of the nervous system) and the practitioner was notified with instructions given to continue the neuro-checks. The immediate intervention implemented was to place the call light within Resident #9's reach and put the Resident's bed in the lowest position. Review of the Neurologic Focused Evaluation dated [DATE] at 9:15 AM, revealed Resident #9 exhibited pain in the right hip and thigh and, unable to assign a pain score and Resident #9 exhibited non-verbal sounds or facial expressions of pain. The Evaluation included the statement, .PRN medication provided. See MAR [Medication Administration Record] for details. Indicators of pain: Protective body movements .Vocal complaints of pain .Facial expressions. Pain Note: Resident is hollering out during care and guarding her right hip and right femur . Review of the MAR for Resident #9 dated [DATE], revealed no documentation that pain medication was administered on [DATE]. Continued review of the MAR revealed a 6 documented in the box where the morning dose (scheduled from 7:00 AM-10:00 AM) should be signed out and LPN L's initials and a 3 in the box where the evening dose should be signed out. An explanation code at the bottom of the MAR indicated the number 6 meant the resident was hospitalized and the number 3 meant the resident was out of the facility. Review of the Nurses' Note for Resident #9 dated [DATE] at 11:31 AM, revealed Resident hollering out and guarding right hip and femur while care being provided, resident has [had] a fall in the early morning, [Named Nurse Practitioner H] .in facility and gave N.O. [New Order] for STAT right hip with pelvis and right femur [x-ray/radiology], resident with pain medication per orders, order placed with [Named Radiology Group] . Review of the physician's order for Resident #9 dated [DATE] at 12:36 PM, revealed an order for a STAT x-ray of the right hip with pelvis and right femur post fall and complaints of pain. Review of the Radiology Results Report for Resident #9 dated [DATE] at 1:32 PM, and reported to the facility at 1:50 PM, revealed an x-ray of the right femur identified an acute appearing periprosthetic fracture. Review of the Nurses' Note for Resident #9 dated [DATE] at 1:48 PM, revealed Spoke with residents [Resident #9's] son regarding residents [resident's] pain in right leg, x-ray tech [technician] suspects a fracture of femur, son agrees with sending resident to hospital for further evaluation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Practitioner Progress Note dated [DATE], revealed . [Resident #9] being seen today for follow up on fall that occurred this morning. Provider alerted by phone this am [AM] that patient had an unwitnessed fall from bed .found on floor .lying on her right side. Per reports, patient had no complaints of pain at that time .Nursing staff now reports patient with guarding. Upon examination, patient attempting to guard right thigh. It is tender to the slightest palpation and patient yells out in any attempt at PROM [passive range of motion]. Stat x-ray ordered of right femur, revealing acute appearing periprosthetic fracture .Acute pain .R/T [related to] Femur fracture, right . Review of the E-INTERACT FORM dated [DATE], revealed Resident #9 was transferred to the hospital at 3:41 PM. Review of the ER documentation for Resident #9 dated [DATE], at 3:43 PM, revealed .1625 [4:25 PM] pt [patient-Resident #9] here per stretcher from [Named Facility] for c/o [complaint of] fall .There is a minimally displaced oblique fracture [break at an angle to the long axis of the bone, the bone is broken all the way through] involving the proximal femoral diaphysis [break in the upper part of the thighbone, specifically in the area of the shaft near the hip] about the stem of the hip arthroplasty hardware [hip replacement device] . Review of the hospital Discharge Summary dated [DATE], revealed Resident #9 was discharged back to the facility in fair condition with discharge diagnoses of Principal Problem: Closed fracture of shaft of right femur . Periprosthetic fracture of femur at tip of prosthesis [near the metal stem of a hip replacement] . Observation in the resident's room on [DATE] at 3:21 PM, revealed Resident #9 lying in bed with her eyes closed, a fall mat was leaned against the wall opposite the Resident's bed, and the Resident's call light was in reach. During an interview on [DATE] at 1:33 PM, the DON stated, .[Resident #9] left out on ,d+[DATE] [2025] at 15:41 [3:41 PM] .this is the transfer form [provided the transfer form and payer change documentation] . The DON was shown Resident #9's MAR and asked did the Resident have any pain medication documented for [DATE]. The DON stated, No, she didn't. The DON was asked should Resident #9 have pain medication documented on the MAR for her pain. The DON stated, Yes .they would have had to call the nurse practitioner [to get an order]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 1:52 PM, NP H confirmed that she typically got to the facility about 10:00 AM. NP H was asked did staff tell her that Resident #9 was in pain. NP H stated, I don't recall .I got there, eval'd [evaluated] her [Resident #9], when I tried to move her leg she screamed, got that STAT x-ray and then we sent her out. NP H was asked did she give an order for pain medication. NP H stated, I did not because she was going out .she was never on pain medicine before the fall .they called the on call [Practitioner] .nothing was ordered because they were told there was no pain. NP H was asked when the resident [Resident #9] began showing signs and symptoms of pain at 9:15 AM, at that time should the staff have requested something for pain. NP H stated, They [the staff] should have told me she [the Resident] was doing that [showing signs and symptoms of pain]. I went in there [to the Resident's room] and attempted to move the leg and she [the Resident] said, 'No, don't, don't, don't [do that] to me, that hurts.' Literally it seems like the STAT x-ray was there within 30 minutes . [the Resident had] no grimacing when laying there, just on movement . NP H was asked in her professional opinion did she think harm there was to the Resident if she lay there in pain for several hours. NP H stated, It's distressing to lay there in pain. I would feel that that would cause harm .harm that couldn't be fixed, no . when they moved her, yeah, that would have produced pain . During a telephone interview on [DATE] at 2:10 PM, LPN L acknowledged she remembered Resident #9's fall on [DATE]. LPN L stated, They [night shift nurse in report] just said she [Resident #9] had fallen .she didn't have any injuries or anything. LPN L was asked did she assess the Resident. LPN L stated, I saw her [the Resident] when I passed out meds, she was just laying in bed like she normally was they hadn't gotten her up yet. LPN L was asked did she conduct a nursing assessment on the Resident or just pass medications. LPN L stated, I didn't do a full assessment, asked her [the Resident] if she was hurting. She didn't appear to be in any distress or anything .acting her same neurologically. LPN L was asked about her documentation of Resident #9's pain on [DATE] at 9:15. LPN L stated, I don't remember the times .just know when they went to get her ready to get up is when she started indicating she was hurting. LPN L was asked how she identified Resident #9's pain in her right hip and thigh. LPN L stated, She was rubbing it .crying or yelling out .I believe I texted the nurse practitioner [NP H], we got an order for a stat x-ray .I believe the nurse practitioner was in the facility when that x-ray was done, anyway she saw it, and it was obviously something not right so we sent her [Resident #9] out [to the hospital]. LPN L was asked about her documentation that stated PRN medication provided see MAR for details and asked what medication was administered. LPN L stated, I honestly can't remember. LPN L was asked was the morning dose of Tylenol [Acetaminophen] administered. LPN L stated, I honestly can't remember. LPN L was asked did she tell NP H how badly Resident #9 was hurting. LPN L stated, I'm sure I did. I don't remember the exact conversation. LPN L was asked did she ask for something more for pain for Resident #9. LPN L stated, No, I think because we were sending her out pretty quick . LPN L was asked about her documentation of Acetaminophen on the MAR that listed a 6 which indicated the resident was hospitalized , and asked did that mean the medication was not administered. LPN L stated, I guess not. LPN L stated she could not remember if Resident #9 received anything for pain from 9:15 AM when she first began to exhibit pain until she transferred to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on [DATE] at 4:46 PM, Resident #9's son stated, She [Resident #9] kept complaining about the pain and so they finally sent her to the hospital . Resident #9's son was asked did the facility staff tell him they were giving the Resident pain medication. Resident #9's son stated, No, she [the Resident] was in so much pain . Resident #9's son was asked did he meet her (Resident #9) at the emergency room and did she appear to be in pain. Resident #9's son stated, Oh yeah, she was really hurting, I thought there was something they could have given her to ease the pain .she would scream out in pain and holler out, 'No, don't do that. You're hurting me' .I really don't know when she got any kind of a pain shot or anything . During an interview on [DATE] at 2:20 PM, the MD was asked should Resident #9 have been given something for pain considering the pain was first documented on [DATE] at 9:15 AM, and per the medical record she did not receive anything for pain before transfer to the hospital. The MD stated, They should have called and gotten a prn [as needed] dose [of pain medication] or something . During an interview on [DATE] at 5:06 PM, the Regional Director of Clinical Operations (RDCO) confirmed the number 6 documented on the MAR meant Resident #9 was at the hospital. The RDCO was shown the MAR and asked according to this MAR did Resident #9 receive her morning dose of Acetaminophen. The RDCO stated, I don't know . An acceptable Removal Plan for F-697 was received on [DATE] and validated on-site on [DATE] through review of pain assessments conducted on [DATE] and [DATE] by the DON, MDS Nurse, and Unit Manager. Review of the facility-wide audit of all residents with pain medication orders included confirmation the ordered pain medication was available on-site. One resident was identified needing a re-fill of pain medication. The order request was sent to the pharmacy on [DATE], the resident received medication from the E-kit until the re-fill arrived the following day. Review of the Pain Assessment/Management In-service training records included review of the sign-in sheet and cross-referenced with the current nursing staff including agency nursing. All nurses currently working had received pain assessment and management in-service training. Multiple interviews were conducted with the nursing staff, during which the nursing staff were asked to describe the training received related to pain assessment, monitoring and management. The nursing staff verbalized training was conducted in person as well as electronically via the online training software. The acceptable Removal Plan included: On [DATE] Resident #17 was readmitted to the facility following surgery. Resident #17's readmission orders included Hydrocodone every six hours as needed. The facility failed to follow up on the Hydrocodone and why it did not arrive from the pharmacy in a timely manner. 1.Root Cause Analysis was completed on [DATE]. Root Cause Findings: The first root cause was that the hospital electronically prescribed the pain to the resident's community pharmacy and not the center's designated pharmacy. Second root cause is a knowledge deficit for the nurses due to not understanding the protocols for following up when a medication is not available. The third root cause is that the nurse practitioner did not reorder the pain medication [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37532 Based on policy review, job description review, personnel record review, facility investigation review, in-service record review, medical record review, observation, and interview, the facility failed to provide sufficient nursing staff with appropriate competencies and skill sets to ensure residents attain or maintain the highest level of practicable physical well-being. The facility failed to ensure competent nursing staff (Certified Nursing Assistant (CNA) R) who immediately reported an allegation of abuse to Administration for 1 of 6 (Resident #1) sampled residents reviewed for allegations of abuse, failed to ensure competent nursing staff (Licensed Practical Nurse (LPN) B and LPN C) who documented controlled substances when administered for 14 of 57 (Resident #7, 8, 13, 22, 27, 29, 31, 32, 33, 34, 35, 36, 41, and 42) sampled residents reviewed for narcotic reconciliation, failed to ensure competent nursing staff (LPN L and LPN Q) who administered medications per the physician's order and as scheduled for 5 of 5 (Resident #6, 13, 16, 24, and 38) residents reviewed for administration of medications, and failed to ensure competent nursing staff (LPN D and LPN L) who appropriately assessed and implemented interventions to address pain and the new onset behavior of attempting to get up unassisted for cognitively impaired residents for 2 of 6 (Resident #17 and 9) sampled residents reviewed for pain assessments and implementation of pain management in cognitively impaired residents with non-verbal pain cues. The findings include: 1. Review of the policy titled, Staffing Guidelines, dated 8/22/2022, revealed It is the policy of the center [facility] to abide by the Federal and Sate staffing guidelines .The center adopts the Federal regulations from the Centers for Medicare and Medicaid Services (CMS) as well as the state regulations for which the center resides as our policies. The staffing and ratios outlined in the regulations will be followed by the Center. Review of the undated facility policy titled, Nursing Services, General, revealed .It is the policy of the facility to provide care and services related to Nursing Services in accordance to State and Federal regulation .This policy will include .Competent Nursing Staff . Review of the facility policy titled, Charting and Documentation, revised 7/2017, revealed .All services provided to the resident .or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . The following information is to be documented in the resident medical record .Medications administered . Treatment or services performed . Review of the facility policy titled, Charting Errors and Omissions, revised 12/2022, revealed .Accurate medical records shall be maintained by this facility .Late entries in the medical record shall be dated at the time of entry and noted as a late entry . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Administration of Drugs, dated 4/2022, revealed .Drugs will be administered in a timely manner and as prescribed by the resident's attending physician or the Center's Medical Director .Unless otherwise specified by the resident's attending physician, routine drugs should be administered as scheduled .The nurse administering the drug must record such information on the residents eMAR [electronic Medication Administration Record] .must electronically sign the resident's eMAR immediately after administration . Review of the undated facility policy titled, Pain Managment, revealed .The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice . 2. Review of the facility Job Description titled, Charge Nurse, revealed .The primary purpose of your job position is to provide direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility .to ensure that the highest degree of quality care is maintained at all times .delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties .Transcribe physician's orders to resident charts .medication cards .Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to the care .Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures .Prepare and administer medications as ordered by the physician .Ensure that an adequate supply of floor stock medications .is on hand to meet the nursing needs of the residents .Notify the Nurse Supervisor of all drugs and narcotic discrepancies noted on your shift .Review medication cards for completeness of information, accuracy in the transcription of the physician ' s order .Dispose of drugs and narcotics as required, and in accordance with established procedures .Notify the resident's attending physician .when there is a change in the resident's condition . 3. Review of the personnel record for Licensed Practical Nurse (LPN) B revealed the LPN Job Description was signed on 4/26/2016. Continued review revealed, .Provide direct nursing care to the residents and supervise the day-to-day nursing activities performed by nursing assistants .in accordance with Federal, State, and Local standards, guidelines and regulations .to maintain the highest degree of quality care at all times .Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures .Prepare and administer medication as ordered by the physician . Verify that narcotic records are accurate for your shift . Review of the personnel record for LPN C revealed the Charge Nurse Job Description was signed and dated on 6/1/2023. Review of the personnel record for LPN L revealed the Charge Nurse Job Description was signed and dated on 5/21/2024. Review of the Nurse Competency Assessment Form in LPN's personnel record dated 5/22/2024, revealed .Demonstrates ability to apply knowledge and skills in a healthcare setting . Demonstrates effective communication .Monitor, document and report all changes in condition appropriately . Understands specific facility client population .Demonstrates proper documentation of medication administration .Consistently, appropriately and correctly documents in EMR [Electronic Medical Record] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the personnel record for LPN D revealed the Charge Nurse Job Description was signed and dated on 10/10/2024. Continued review of the Nurse Competency Assessment Form dated 10/24/2024, revealed . Demonstrates ability to apply knowledge and skills in a healthcare setting .Demonstrates effective communication .Monitor, document and report all changes in condition appropriately .Understands specific facility client population .Demonstrates proper documentation of medication administration .Consistently, appropriately and correctly documents in EMR . Review of the personnel record for Certified Nursing Assistant (CNA) R revealed the CNA Job Description was signed and dated 1/2/2025. Continued review revealed .Report all allegations of resident abuse . 4. The facility failed to ensure competent staff who immediately reported allegations of abuse. a. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Diabetes, Human Immunodeficiency Virus Disease, Depression, and Encephalopathy. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 14. Review of the progress notes dated 2/27/2025, revealed Resident #1 reported to RN A that a male staff member had sexually abused him by digital penetration of the rectum. RN A called the Administrator immediately and reported the allegation and Resident #1 was transported to the emergency room (ER). During an interview on 3/4/2025 at 3:29 PM, Certified Nursing Assistant (CNA) R stated she was told by Resident #1 on 2/26/2025 that a male staff member raped him. CNA R stated .the new nurse .was [NAME] [missing in action] .he was nowhere to be found .I had an Uber waiting on me . CNA R stated she reported the allegation of abuse to facility staff the following day (2/27/2025). CNA R stated, .I'm sorry .I know you have to tell right away .now I know to tell any nurse in charge. I feel bad . b. CNA R had previously attended an Abuse inservice on 2/5/2025, but did not report the abuse on 2/26/2025, when the resident reported the allegation. 5. The facility failed to ensure competent nursing staff documented controlled substances when administered: a. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE]. Review of the Medication Administration Audit Report for Resident #7 dated 3/4/2025 at 9:07 AM, revealed Lacosamide (medication to control seizures) 50 mg tablet was administered to Resident #7. Observation and interview at the B Hall medication cart with LPN C on 3/4/2025 beginning at 11:31 AM, with LPN C, revealed a discrepancy of Resident #7's Lacosamide 50 mg tablets between the medication card and the Controlled Drug Record. The medication card contained 6 Lacosamide tablets and the Controlled Drug Record documented there should be 7 Lacosamide tablets presents. LPN C confirmed the discrepancy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	b. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE]. Review of Resident #8's physician's orders dated 2/6/2025, revealed an order for Percocet (Oxycodone-Acetaminophen) 5-325 mg one time a day. Observation and interview at the B Hall medication cart with LPN C on 3/4/2025 beginning at 11:31 AM, revealed a discrepancy of Resident #8's Oxycodone-Acetaminophen 5-325 mg tablets between the medication card and the Controlled Drug Record. The medication card contained 28 Oxycodone-Acetaminophen tablets. and the Controlled Drug Record documented there should be 29 Oxycodone-Acetaminophen tablets present. LPN C confirmed the discrepancy. c. Review of the medical records revealed Resident #13 was admitted to the facility on [DATE]. Review of Resident #13's physician's orders dated 3/6/2025, revealed Norco (Hydrocodone-Acetaminophen) 7.5-325 mg 4 times a day. Observation and interview at the B Hall medication cart with LPN C on 3/4/2025 beginning at 11:31 AM, revealed a discrepancy of Resident #13's Hydrocodone-Acetaminophen 7.5-325 mg tablets between the medication card and the Controlled Drug Record. The medication card contained 9 Hydrocodone-Acetaminophen tablets, and the Controlled Drug Record documented 10 Hydrocodone-Acetaminophen tablets should be present. LPN C confirmed the discrepancy. d. Review of the medical records revealed Resident #22 was admitted to the facility on [DATE]. Review of Resident #22's physician's orders dated 2/6/2025, revealed an order for Lorazepam 0.5 mg twice a day for anxiety. Observation and interview at the B Hall medication cart with LPN C on 3/4/2025 beginning at 11:31 AM, revealed a discrepancy of Resident #22's Lorazepam tablets between the medication card and the Controlled Drug Record. The medication card contained 17 Lorazepam tablets, and the Controlled Drug Record documented there should be 18. LPN C confirmed the discrepancy. e. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE]. Review of Resident #27's physician's orders dated 2/14/2025, revealed an order for Hydrocodone-Acetaminophen 5-325 mg every 6 hours as needed (PRN) for pain. Observation and interview at the C Hall Medication Cart with LPN B on 3/4/2025 beginning at 11:23 AM, revealed a discrepancy of Resident #27's Hydrocodone-Acetaminophen 5-325 milligrams (mg) tablets between the medication card and the Controlled Drug Record. The medication card contained 39 Hydrocodone-Acetaminophen tablets, and the Controlled Drug Record documented there should be 40 Hydrocodone-Acetaminophen tablets present. LPN B acknowledged she administered the Hydrocodone-Acetaminophen and failed to sign it out when it was administered. f. Review of the medical record revealed Resident #29 was admitted to the facility on [DATE]. Review of Resident #29's physician's orders dated 2/6/2025, revealed an order for Tramadol Hydrochloride (HCL) 50 mg two times a day for pain and every 6 hours PRN for pain. Observation and interview at the B Hall medication cart with LPN C on 3/4/2025 beginning at 11:31 AM, revealed a discrepancy of Resident #29's Tramadol HCL 50 mg tablets between the medication card and the Controlled Drug Record. The medication card contained no Tramadol tablets, and the Controlled Drug Record documented there should be 1 tablet present. LPN C confirmed the discrepancy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	g. Review of the medical record revealed Resident #31 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #31's physician ' s orders dated 2/6/2025, revealed an order for Xanax (Alprazolam) 0.25 mg two times a day. Observation and interview at the B Hall medication cart with LPN C on 3/4/2025 beginning at 11:31 AM, revealed a discrepancy of Resident #31's Alprazolam 0.25 mg tablets between the medication card and the Controlled Drug Record. The medication card contained 32 Alprazolam tablets, and the Controlled Drug Record documented there should be 33 Alprazolam tablets present. LPN C confirmed the discrepancy. h. Review of the medical record revealed Resident #32 was admitted to the facility on [DATE]. Review of Resident #32's physician's orders dated 2/6/2025, revealed an order for Lacosamide 150 mg two times a day for seizures. Observation and interview at the B Hall medication cart with LPN C beginning at 11:31 AM, revealed a discrepancy of Resident #32's Lacosamide 150 mg tablets between the medication card and the Controlled Drug Record. The medication card contained 8 Lacosamide tablets and the Controlled Drug Record documented there should be 9 Lacosamide tablets present. LPN C confirmed the discrepancy. i. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident #33's physician's orders dated 2/6/2025, revealed an order for Pregabalin 75 mg, 2 capsules one time a day related to Chronic Pain Syndrome and give 1 capsule one time a day for Chronic Pain Syndrome. 2 capsules were scheduled to be administered at bedtime and 1 capsule in the morning. Observation and interview at the B Hall medication cart with LPN C on 3/4/2025 beginning at 11:31 AM, revealed a discrepancy of Resident 33's Pregabalin 75 mg capsules between the medication card and the Controlled Drug Record. The medication card contained 25 Pregabalin capsules and the Controlled Drug Record documented there should be 26 Pregabalin present. LPN C confirmed the discrepancy. j. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE]. Review of Resident #34's physician's orders dated 2/21/2025, revealed an order Alprazolam 0.25 mg three times a day related to Anxiety Disorder. Observation and interview at the B Hall medication cart with LPN C on 3/4/2025 beginning at 11:31 AM, revealed a discrepancy of Resident #34's Alprazolam 0.25 mg tablets between the medication card and the Controlled Drug Record. The medication card contained 18 Alprazolam tablets and the Controlled Drug Rcord documented there should be 19 Alprazolam tablets present. k. Review of the medical record revealed Resident #35 was admitted to the facility on [DATE]. Review of Resident #35's physician's orders dated 2/6/2025, revealed Xanax 0.25 mg four times a day for Anxiety Disorder. Observation and interview at the B Hall medication cart with LPN C on 3/4/2025 beginning at 11:31 AM, revealed a discrepancy of Resident #35's Alprazolam (Xanax) 0.25 mg tablets between the medication card and the Controlled Drug Record. The medication card contained 20 Alprazolam tablets, and the Controlled drug Record documented there should be 21 Alprazolam tablets present. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/4/2025 at 11:45 AM, LPN C acknowledged the facility's policy was to sign off the controlled substances when they were administered and stated, .but you caught us on a busy day. During an interview on 3/5/2025 at 9:55 AM, the DON stated controlled substances should be signed out on the Controlled Drug Record when they were pulled from the medication cart. l. Review of the medical record revealed Resident #36 was admitted to the facility on [DATE]. Review of Resident #36's physician's orders dated 2/13/2025, revealed Hydrocodone-Acetaminophen 5-325 mg three times daily. Observation and interview at the B Hall medication cart with LPN C on 3/4/2025 beginning at 11:31 AM, revealed a discrepancy of Resident #36's Hydrocodone-Acetaminophen 5-325 mg tablets between the medication card and the Controlled Drug Record. The medication card contained 26 Hydrocodone-Acetaminophen tablets and the Controlled Drug Record documented there should be 27 Hydrocodone-Acetaminophen tablets present. LPN C confirmed the discrepancy. m. Review of the medical records revealed Resident #41 was admitted to the facility on [DATE]. Review of Resident #41's physician's order dated 2/6/2025, revealed an order for Alprazolam 0.5 mg two times a day for anxiety and Norco 7.5-325 mg (Hydrocodone-Acetaminophen) 4 times a day for Phantom Limb Pain. Observation and interview at the B Hall medication cart with LPN C on 3/4/2025 beginning at 11:31 AM, revealed a discrepancy of Resident #41's Alprazolam 0.5 mg tablets between the medication card and the Controlled Drug Record. The medication card contained 28 Alprazolam tablets, and the Controlled Drug Record documented there should be 29 Alprazolam tablets present. Continued observation revealed a discrepancy of Resident #41's Hydrocodone-Acetaminophen 7.5-325 mg tablets between the medication card and the Controlled Drug Record. The medication card contained 31 Hydrocodone-Acetaminophen tablets, and the Controlled Drug Record documented there should be 32 Hydrocodone-Acetaminophen tablets present. LPN C confirmed the discrepancy. n. Review of the medical records revealed Resident #42 was admitted to the facility on [DATE]. Review of Resident #42's physician's orders dated 2/6/2025, revealed an order for Gabapentin 400 mg two times a day for diabetes with polyneuropathy. Observation and interview at the B Hall medication cart with LPN C on 3/4/2025 beginning at 11:31 AM, revealed a discrepancy of Resident #42's Gabapentin 400 mg capsules between the medication card and the Controlled Drug Record. The medication card contained 33 Gabapentin capsules, and the Controlled Drug Record documented there should be 34 Gabapentin capsules present. LPN C confirmed the discrepancy. 6. The facility failed to ensure competent nursing staff who administered medications per the physician's order and as scheduled: Review of the undated facility document titled, MED [Medication] PASS TIME FRAMES, revealed .One time a day = [equals .7-10a [7:00-10:00 AM] or 7-10p [7:00-10:00 PM] .TID [three times a day] .enter 0500 [5:00 AM], 1300 [1:00 PM], 2100 [9:00 PM] .QID [four times a day] & [and] q6 [every 6 hours] .enter 0500 [5:00 AM], 1100 [11:00 AM], 1700 [5:00 PM], 23:00 [11:00 PM . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a. Review of the medical record revealed Resident #6 was readmitted on [DATE], with diagnoses of Parkinson's Disease, Contracture of ankle, and muscle spasms. Review of the Minimum Data Set (MDS) dated [DATE], revealed Resident #6 was cognitively intact and required use of a wheelchair for mobility. Review of the physician's orders dated 1/2/2025 for Resident #6 revealed Carbidopa Levodopa ER (extended release) oral tablet 25-100 milligram (mg) give 1 tablet by mouth every three hours for Parkinson's Disease, Entacapone 200 mg give 1 tablet by mouth every 3 hours for Parkinson's Disease, Ropinirole Hydrochloride (HCL) 0.5 mg give 1 tablet by mouth 3 times a day for Parkinson's, Tizanidine HCl 4mg give 1 tablet by mouth 3 times a day for Contracture, and Gabapentin 800 mg give 1 tablet by mouth 3 times a day for Parkinson's Disease. Review of the physician's orders dated 2/18/2025, Resident #6 Carvidopa 50-200 mg give 1 tablet by mouth four times a day for Parkinson's Disease, Diazepam 2mg give 1 tablet by mouth three times a day for Anxiety disorder and muscle spasms. Review of the Medication Admin (Administration) Audit Report, which indicated the actual time medications were documented as being administered, dated 3/14/2025 revealed the following medications were not documented as being administered accurately: The Ropinirole HCl 0.5 mg scheduled for 5:00 AM was documented as administered at 9:24 AM. The Tizanidine HCl 4 mg scheduled for 5:00 AM was documented as administered at 9:24 AM. The Gabapentin 800 mg scheduled for 6:00 AM was documented as administered at 9:24 AM. The Entacapone 200 mg give 1 tablet scheduled for 6:00 AM was documented as administered at 9:24 AM. The Carbidopa- Levodopa 25-100 mg dose scheduled for 6:00 AM was documented as administered at 9:24 AM. The Diazepam 2 mg scheduled for 6:00 AM was documented as administered at 9:24 AM. The Ropinirole HCl 0.5 mg scheduled for 9:00 PM was documented as administered at 11:34 PM. The Tizanidine HCl 4 mg scheduled for 9:00 PM was documented as administered at 11:33 PM. The Entacapone 200 mg scheduled for 9:00 PM was documented as administered at 11:33 PM. The Carbidopa-Levodopa 25-100 mg was scheduled for 9:00 PM was documented as administered at 11:33 PM. During an interview on 3/18/2025 at 2:26 PM, Resident #6 stated on 3/14/2025, the night nurse did not administer his medicine as scheduled. Resident #6 stated, this problem comes and goes, depending on the number of agency nurses working. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During interview on 3/20/25 12:05 PM, the DON acknowledged the medication administration audit form revealed Resident #6's medication was not administered as scheduled per the physician order and the medication administration was not documented timely and accurately. b. Review of the medical records revealed Resident #13 was admitted to the facility on [DATE], with diagnoses including Diabetes, Dependence on Renal Dialysis, Hypothyroidism, Anxiety, Bipolar Disorder, and Insomnia. Review of Resident #13's physician's orders dated 2/6/2025, revealed the following: Insulin Lispro (fast-acting insulin to lower blood glucose) 100 Unit/ML inject per sliding scale before meals: for a blood glucose of 71-150 mg/dL give 0 units, for a blood glucose of 151 - 200 mg/dL give 2 units, for a blood glucose of 201-250 mg/dL give 4 units, for a blood glucose of 251-300 mg/dL give 6 units, for a blood glucose of 301-350 mg/dL give 8 units, for a blood glucose of 351-400 mg/dL give 10 units, and for a blood glucose of 401 mg/dL or higher give 10 units and recheck in one hour, if blood sugar (glucose) has not gone down, notify the Nurse Practitioner (NP). Norco (Hydrocodone-Acetaminophen) 7.5-325 mg, give 1 tablet by mouth four times a day for pain. Buspirone Hydrochloride (HCL) 10 mg, give 1 tablet by mouth two times a day for depression. Montelukast Sodium 10 mg, give 1 tablet by mouth one time a day for allergies. Ezetimibe 10 mg, give 1 tablet by mouth one time a day for Hyperlipidemia. Fluticasone Propionate Nasal Suspension 50 micrograms/actuation (mcg/act), 1 spray alternating nostrils two times a day for Allergic Rhinitis. Sennosides-Docusate (Senna-S) 8.6-50 mg, give 2 tablets by mouth one time a say for Constipation. Review of the MAR for Resident #13 dated 2/1/2025-2/28/2025, revealed Resident #13's blood glucose was 233 mg/dl on 2/26/2025 at 7:30 AM and 4 units of Lispro Insulin was administered. Continued review revealed Resident #13's blood glucose was 264 mg/dL on 2/26/2025 at 12:00 PM and 6 units of Lispro Insulin were administered. Review of the Medication Admin (Administration) Audit Report (report which indicated the actual time medications were documented as given) for Resident #13 dated 2/25/2025-2/27/2025, revealed the following: Lispro Insulin scheduled to be administered per sliding scale on 2/26/2025 at 7:30 AM, before breakfast, was documented as administered at 2:20 PM, 6 hours and 50 minutes late. Lispro Insulin scheduled to be administered per sliding scale on 2/26/2025 at 12:00 PM, before lunch, was documented as administered at 2:21 PM, 2 hours and 21 minutes late. Resident #13's 7:30 AM dose of Insulin and her 12:00 PM dose of Insulin were documented as administered 1 minute apart. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Norco scheduled to be administered on 2/26/2025 at 11:00 AM, was documented as administered at 2:20 PM, 3 hours and 20 minutes late. Buspirone 10 mg tablet scheduled for 2/27/2025 at 7:00 PM-10:00 PM was documented as administered on 2/28/2025 at 1:51 AM, 3 hours and 51 minutes late. Montelukast Sodium 10 mg tablet scheduled on 2/27/2025 at 7:00 PM-10:00 PM was documented as administered on 2/28/2025 at 1:51 AM, 3 hours and 51 minutes late. Ezetimibe 10 mg tablet scheduled on 2/27/2025 at 7:00 PM-10:00 PM was documented as administered on 2/28/2025 at 1:52 AM, 3 hours and 52 minutes late. Fluticasone Propionate Nasal spray scheduled on 2/27/2025 at 7:00 PM-10:00 PM was documented as administered on 2/28/2025 at 1:52 AM, 3 hours and 52 minutes late. Senna-S 8.6-50 mg scheduled on 2/27/2025 at 7:00 PM-10:00 PM was documented as administered on 2/28/2025 at 1:53 AM, 3 hours and 53 minutes late. Review of the working schedule dated 2/27/2025, revealed LPN Q worked the B Hall where Resident #13 resided on 2/27/2025. Observation and interview in the Resident's room on 3/13/2025 at 9:20 AM, revealed Resident #13 lay in bed, oxygen was administered by nasal cannula at 3 liters per minute. Resident #13 confirmed she had been in the facility about 4 years. Resident #13 stated, One day .they had a nurse in, I didn't get my night medicine I asked him about it and he said no I gave it to you, you were asleep, come to find out the next morning there was a lot of people that didn't get their medication so he's not coming back .[Named LPN Q] . During an interview on 3/26/2025 at 12:46 PM, LPN L reviewed Resident #13's Medication Admin Audit Report. LPN L stated Resident #13 was not even in the facility at 2:20 PM and 2:21 PM on 2/26/2025 (2/26/2025 was a dialysis day for Resident #13 and she left the facility at approximately 11:00 AM). LPN L stated the 7:30 Lispro Insulin was given before breakfast and the 11:00 AM dose of Norco and the 12:00 PM dose of Lispro and were given right before the resident left for dialysis. LPN L stated, That ' s probably just when I was able to chart it [Lispro Insulin and Norco] . c. Review of the medical records revealed Resident #16 was admitted to the facility on [DATE]. Review of Resident #16's physician's orders dated 3/6/2025, revealed Levothyroxine Sodium 137 micrograms [MCG], give 1 tablet by mouth one time a day related to Hypothyroidism (where the thyroid gland does not produce enough thyroid hormone) and Furosemide 20 mg, give 1 tablet by mouth one time a day for edema. Review of the Medication Admin Audit Report for Resident #16 dated 3/14/2025, revealed the Levothyroxine Sodium 137 MCG [micrograms] scheduled at 4:00 AM, was documented as administered at 1:06 PM, 9 hours late. Continued review revealed the Furosemide 20 mg scheduled at 5:00 AM, was documented as administered at 1:06 PM, 8 hours late. d. Review of the medical record revealed Resident #24 was admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #24 physician's order dated 3/6/2025, revealed Simethicone 125 mg by mouth before meals and at bedtime for heartburn and indigestion; Tamsulosin Hydrochloride (HCL) 0.4 mg, 2 capsules at bedtime for an enlarged prostate; Risperdal 1 mg at bedtime related to Schizophrenia; Gabapentin 600 mg, give 1 tablet three times a day for polyarthritis (arthritis in five or more joints simultaneously); Clonazepam 1 mg, 1.5 tablets at bedtime related to Generalized Anxiety Disorder; and Mesalamine Rectal Suppository, 1000 mg at bedtime related to Constipation. Review of the Medication Admin Audit Report for Resident #24 dated 3/14/2025-3/16/2025, revealed the following medications were scheduled for 3/14/2025 at 9:00 PM, and were documented as administered on 3/15/2025 at 12:01 AM, 3 hours late: Simethicone 125 mg Tamsulosin HCL 0.4 mg Risperdal 1 mg Gabapentin 600 mg, Clonazepam 1 mg Mesalamine Rectal Suppository 1000 mg. e. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE], with diagnoses including Dementia, Diabetes, Bipolar Disorder, Schizophrenia, Insomnia, Osteoarthritis, and Depression. Review of the Resident #38's physician's orders dated 3/6/2025, revealed Acetaminophen 650 mg, 2 tablets by mouth three times a day; Gabapentin 800 mg, three times a day; Ziprasidone (medication to treat psychosis) 20 mg at bedtime; Ziprasidone 80 MG at bedtime; Lamictal (a medication to treat seizures and bipolar disorder) 100 MG at bedtime. Review of the Medication Admin Audit Report for Resident #38 dated 3/15/2025, revealed the following: Acetaminophen 650 mg scheduled at 9:00 PM was documented as administered on 3/16/2025 at 1:44 AM, 3 hours and 44 minutes late. Lamictal 200 mg scheduled at 9:00 PM was documented as administered on 3/16/2025 at 2:13 AM, 4 hours and 13 minutes hours late. Gabapentin 800 mg scheduled at 9:00 PM was documented as administered on 3/16/2025 at 2:14 AM, 4 hours and 14 minutes hours late. Ziprasidone 20 mg scheduled at 9:00 PM was documented as administered on 3/16/2025 at 2:16 AM, 4 hours and 16 minutes hours late (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ziprasidone 80 mg scheduled at 9:00 PM was documented as administered on 3/16/2025 at 2:16 AM, 4 hours and 16 minutes hours late. Observation and interview on 3/17/2025 at 12:20 PM, revealed Resident #38 sitting in her wheelchair in her room and the Resident stated, .didn ' t get our meds last night till 2:30 the next morning .agency nurse she didn't know what she was doing . During an interview on 3/26/2025 at 3:38 PM, the DON acknowledged the facility was having issues with medications being administered as ordered. The DON stated, .it's [medication administration] being spotty and we ' re trying to get every agency person in here for additional training .the ones who are not performing, I'm not letting them come back. The DON was asked would you say staff are following the instructions and the in-services provided following the drug diversion (in October 2024) and signing out narcotics when administered. The DON stated, No. I went as far as demonstrating when you pull your pills, I walked them through each step of administration . The DON was asked would you say this is not an education issue because the staff were educated, but rather this is a staff performance issue. The DON stated, Yes, ma'am and I walk around and say be sure you're signing as soon as it [medication] pops out of that cart. The DON was asked would you say that would be the same issue with the staff member who did not report an allegation of sexual abuse until the following day. The DON stated, Yes, they were not following directions . 7. The [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 37532 Based on policy review, Pharmacy Services Agreement, Law Enforcement Investigation, facility investigation, medication reconciliation document review, medical record review, facility document review, observation, and interview, the facility failed to have a system of recording, accurate reconciliation, and accounting for all controlled medication, failed to promptly identify diversion of controlled substances, failed to provide medications according to physician orders and per facility policy, and failed to ensure controlled substances were in date and no discrepancies were identified for 31 of 57 (Residents #6, 7, 8, 9, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 38, 41, and 42) sampled residents reviewed for controlled substance reconciliation, drug diversion, and medication administration. The findings include: 1. Review of the Pharmacy Services Overview Policy, revised [DATE], revealed, .the facility shall accurately and safely provide or obtain pharmacological services, including the provision of routine and emergency medications .Policy interpretation and implementation .Pharmaceutical services consist of .a. the process of receiving and interpreting prescribers' orders; acquiring, receiving, storing, controlling, reconciling, compounding, dispensing, packaging, labeling, distributing, administering, monitoring responses to, using and or disposing of all medications .b. the provision of medication- related information to health care professionals and residents .c. the process of identifying, evaluating and addressing medication - related issues including the prevention and reporting of medication errors .d. The provision, monitoring and/or the use of medication-related devices .Pharmacy services are available to residents 24 hours a day, seven days a week .Residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner .Nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting pharmacy if a resident's medication is not available for administration . Medications are received, labeled, stored, administered and disposed of according to all applicable state and federal laws and consistent with standards of practice .The consultant pharmacist, in collaboration with the dispensing pharmacy and the facility, oversees the development of procedures related to pharmacy services including (but not limited to) .acquisition and availability of medications .receipt, labeling and storage of medications .reconciliation of medications from the pharmacy .control of medications from point of receipt to secured storage areas .facility staff roles and responsibilities during the receipt and storage of medication . administration of medications, disposition of medications . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Medication Ordering and Receiving From Pharmacy Provider Emergency . Emergency Kits (E-Kits), dated ,d+[DATE], revealed .Emergency pharmaceutical service is available on a 24-hour basis. Emergency needs for medication are met by using the nursing care center ' s approved emergency medication supply or by special order from the provider pharmacy. Emergency medications and supplies are provided by the pharmacy in compliance with applicable state and federal regulations .The provider pharmacy supplies emergency or stat [immediate or urgent] medications/items according to the provider pharmacy agreement. Emergency medications and supplies are .checked periodically for integrity and dating and stored in accordance with .federal regulations .When an emergency or stat medication is needed, the nurse first verifies and reviews the prescriber's orders for appropriateness, checks the resident ' s allergies, and removes the required non-controlled medication from the emergency kit .Upon removal of any medication or supply item from the emergency kit, the nurse documents the medication .used on an emergency kit log .One copy of this information should be immediately faxed to the pharmacy or placed within the resealed emergency kit until it is scheduled for exchange .Items to be documented on the log include .Resident's name .Medication name, strength and quantity .Date and time of medication removal . Prescriber's name .Date and time pharmacy notified .Signature of nurse removing and administering dose . The nursing staff, consultant pharmacist and provider pharmacy designee checks the emergency kits regularly for expiration dating of the contents. The date of expiration is noted on the outside of the kit .If hard copy Prescriber signed prescription is available .Nurse will contact pharmacist to communicate need to access E-kit .Nurse will fax hard copy prescription to pharmacist .Once the pharmacist confirms receipt of a valid prescription, the pharmacist will contact facility nurse to communicate .Authorization to access emergency kit .Specific prescription details .Number of authorized entries to E-kit .Number of doses per entry to E-kit . Review of the facility policy titled, Controlled Substances, revised ,d+[DATE], revealed .The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications . Review of the facility policy titled, Pharmacy Services, reviewed ,d+[DATE], DISCARDING AND DESTROYING MEDICATIONS .medications will be disposed of in accordance with federal, state and local regulations governing management of .controlled substances .All unused controlled substances shall be retained in a securely locked area with restricted access until disposed of .Schedule V (non-hazardous) controlled substances will be disposed of in accordance with state regulations and federal guidelines . Schedule II .and IV (non-hazardous) controlled substances will be disposed of in accordance with state regulations and federal guidelines .If a resident is transferred to another facility, or dies while he or she is in lawful possession of controlled substance(s) by depositing in the authorized on-site collection receptacle . must take place immediately (no longer than three days after discontinuation of use by the resident . Completed medication disposal records shall be kept on file in the facility for at least two (2) years, or as mandated by state law governing the retention and storage of such records . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy titled, Administration of Drugs, dated ,d+[DATE], revealed .Drugs will be administered in a timely manner and as prescribed by the resident's attending physician or the Center's [facility's] Medical Director .Drugs may not be set up in advance and must be administered within one (1) hour before or after their prescribed time .Unless otherwise specified by the resident's attending physician, routine drugs should be administered as scheduled .The nurse administering the drug must record such information on the residents eMAR [electronic Medication Administration Record] .The nurse administering the drugs must electronically sign the resident's eMAR immediately after administration . Review of the facility policy titled, Person-Centered Medication Administration Schedule, revised [DATE], revealed .Medications shall be administered according to established durations to allow for a more relaxed, person-centered schedule . Review of the PHARMACY SERVICES AGREEMENT, dated and signed on [DATE], revealed Pharmacy Services Agreement .is made between Pharmacy Corporation of America .and [Named Facility Management Company] .The parties agree as follows .Pharmacy shall provide services set forth in this Agreement to Client and persons in care of the Customer (the Residents .) in accordance with terms and conditions of this Agreement, and any Schedules .or policies and procedures of the Manual .which are incorporated into this agreement .3. OBLIGATIONS OF THE PHARMACY .Pharmacy shall provide to Client and deliver to the Customer prescription and non-prescription drugs, biologicals .and Services as set forth in this Agreement, in accordance with the orders of the Residents ' licensed prescribers as provided to the Pharmacy by Customer, and the Customer ' s own orders .B. Pharmacy shall provide, maintain and replenish emergency drug supply kits (the Emergency Kits) as permitted by Applicable Law .F. The parties anticipate that Customer shall use best efforts to provide Medications to Resident at time of discharge or return Products to Pharmacy. Pharmacy shall manage Product returns in accordance with its then current return policy as specified in the Manual .4. Obligations of the Client [facility] .Comply with .Drug Enforcement Agency (DEA) requirements relating to the submission of prescriptions for controlled substances, including, but not limited to, promptly providing Pharmacy with copies of prescriptions for Medications .properly execute physician prescription for all controlled substance Medication orders .Document usage of Emergency Kits .H. Store and handle all medications in accordance with Applicable Law .Nurse Consulting Services .[Named Pharmacy Company] employs a Nurse Consulting Services organization intended to satisfy specific service needs of the Customer .employs qualified pharmacy technicians and nurses who upon request can be called upon to perform the following .Perform medication cart audits .check of all Medications for .date opened and expiration dates .removal of all discontinued Medications .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)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. Review of the Law Enforcement investigation dated [DATE], revealed Investigator #1 conducted a traffic stop of Licensed Practical Nurse (LPN) M for a window tint violation on [DATE]. LPN M was found with miscellaneous pills in the floorboard of her car and a probable cause search warrant was conducted of the vehicle. Investigators found multiple pill blister packs (a card of medication with the pills showing in clear windows on the front and the ability to pop the pills out on the back of the card) of non-scheduled and scheduled prescription medications containing names of different people. [Named LPN M] advised on scene that the prescription pill blister packets were from deceased patients that she had worked with .advised that she worked with patients at a long term care facility. Some of the prescription pill blister packets dated back to the year 2020. Also located inside of [Named LPN M] vehicle was a green cloth bag that contained over 15 small plastic baggies containing non scheduled prescription drugs and scheduled prescription drugs all packaged separately for resale, the schedule drugs ranged from Schedule II Morphine and Hydrocodone, Schedule IV Lorazepam to Xanax and Schedule V Gabapentin and Pregabalinand [Pregabalin] . Continued review of the Law Enforcement Investigation revealed LPN M ' s home was also searched and Investigators found a total of 704.5 pills in her car and 1,225 pills in her home for a total of 1,929.5 pills seized by authorities. LPN M was taken into custody and formally charged with Unlawful Window Tint, Unlawful Possession without Prescription, and Possess Controlled Substance with Intent to Manufacture, Deliver, or Sell Controlled Substance for Schedule II (3 counts), Schedule IV (4 counts), and Schedule V (3 counts) drugs. 3. Review of the facility investigation revealed the facility was provided a list of 109 residents' names affected by the drug diversion of LPN M on [DATE]. Review of a typewritten statement by the Administrator dated [DATE], revealed she was notified on [DATE] that (LPN M) was detained on drug charges. On [DATE], the Drug Enforcement Agency (DEA) served the facility with a search warrant on the drug diversion. The residents identified were discharged , deceased , or the medications were expired .No adverse effects have been identified .I [Administrator] had no prior knowledge of any incidents regarding the missing medications .The investigation concluded that (LPN M) removed various types of medications from the facility .The employee was termed on [DATE], due to employee failing to return to work .The root cause is the drug destruction process was not followed properly by the nurse . Review of the typewritten statement by the Director of Nursing (DON) signed and dated [DATE], revealed the DON was notified on [DATE] by the day shift nurse on A Hall that the Unit Manager (LPN M) would be late because of a traffic stop. After an hour had passed LPN M had still not arrived at work. The DON made multiple attempts through the night to reach LPN M by phone without success. The DON and the Administrator met with 2 investigators from the District Attorney's Office of Drug Enforcement in the facility lobby on [DATE] and were notified that LPN M was in custody for drug related charges, she had narcotics (controlled substances) from the facility and narcotic tracking sheets with residents' information, in addition to miscellaneous (non-scheduled) medications. The DON and the Administrator met with DA Drug Enforcement, DEA, and the [Named City where facility was located] Police Department at different times. Because all evidence is in the possession of law Enforcement I [DON] was unable to perform a thorough investigation. However, I do know I delegated to [Named LPN M] to assist with pulling of narcotics from the medication carts for destruction. She was part of a trusted management team. I am unaware exactly how she accomplished this without my knowledge. Upon becoming aware of the situation narcotic audits were completed, reviewed policies and procedures with nursing staff and conducted interviews. The Narcotic audits did not find any discrepancies . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4a. Review of the medical records revealed Resident #13 was admitted to the facility on [DATE], with diagnoses including Diabetes, Dependence on Renal Dialysis, Hypothyroidism, Anxiety, Bipolar Disorder, and Insomnia. Review of the physician orders for Resident #13 dated [DATE], revealed Tizanidine Hydrochloride (HCL) (a muscle relaxer, non-scheduled medication) 2 mg was ordered four times a day. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #13's pill blister pack of Tizanidine HCL 2 mg, card 1 of 4, dated [DATE] was found in LPN M's possession. There were zero (0) of 60 Tizanidine tablets remaining in the blister pack. Continued review revealed Resident #13's blister pill pack for Tizanidine HCL 2 mg, card 2 of 4, dated [DATE] was found in LPN M's possession. There were 7 of 60 Tizanidine tablets remaining in the blister pack. b. Review of the closed medical record revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including Diabetes, Dependence on Renal Dialysis, Hypothyroidism, Anxiety, Bipolar Disorder, and Insomnia. Review of the physician orders for Resident #14 dated [DATE], revealed Ativan (Lorazepam - a medication for anxiety) 0.5 mg was ordered every 12 hours as needed (PRN) for anxiety and agitation and Percocet (medication for pain) ,d+[DATE] mg was ordered mouth two times a day every 6 hours as needed for pain and two times a day for pain. Review of the physician orders for Resident #14 dated [DATE], revealed Gabapentin (medication for seizures and nerve pain) 100 mg was ordered two times a day for diabetic neuropathy. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #14's blister pill pack of Lorazepam 0.5 mg, a Schedule IV controlled substance dated [DATE] was found in LPN M's possession. There were 0 of 50 Lorazepam tablets remaining in the blister pack. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #14's blister pill pack of Percocet (Oxycodone-Acetaminophen) ,d+[DATE] mg, a Schedule II controlled substance, dated [DATE] was found in LPN M's possession. There were 0 of 60 Percocet tablets remaining in the blister pack. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #14's blister pill pack of Percocet ,d+[DATE] mg a Schedule II controlled substance dated [DATE] was found in LPN M's possession. There were 0 of 60 Percocet tablets remaining in the blister pack. c. Review of the closed medical record revealed Resident #15 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes, Bipolar Disease, Anxiety and Insomnia Review of the physician's orders for Resident #15 dated [DATE], revealed Gabapentin 100 mg was ordered three times a day for neuropathy (weakness, numbness, and pain from nerve damage and pain), Diazepam 5 mg was ordered every 12 hours as needed for anxiety for 14 days, and Hydrocodone-Acetaminophen , d+[DATE] mg was ordered every 6 hours as needed for pain for 14 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #15's blister pill pack of Hydrocodone-Acetaminophen ,d+[DATE] mg, a Schedule II controlled substance, dated [DATE] was found in LPN M's possession. There were 0 of 12 Hydrocodone-Acetaminophen tablets remaining in the blister pack. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #15's blister pill pack of Diazepam 5 mg, a Schedule IV controlled substance, dated [DATE] was found in LPN M's possession. There were 0 of 12 Diazepam tablets remaining in the blister pack. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #15's blister pill pack of Gabapentin 100 mg, a Schedule V controlled substance, dated [DATE] was found in LPN M's possession. There were 45 of 45 Gabapentin capsules remaining in the blister pack. d. Review of the closed medical record revealed Resident #18 was admitted to the facility on [DATE], with diagnoses including Diabetes, Chronic Pain Syndrome, and Anxiety. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #18's blister pill pack of Alprazolam 0.25 mg, a Schedule IV controlled substance, dated [DATE] was found in LPN M's possession. There were 0 of 60 remaining in the blister pack. Review of the physician orders for Resident #18 dated [DATE], revealed Alprazolam (medication used to treat anxiety/depression) 0.5 mg was ordered by mouth three times a day. e. Review of the closed medical record revealed Resident #19 was admitted to the facility on [DATE], with diagnoses including Prosthesis, Depression, Osteoarthritis, and Anxiety. Review of the physician orders from a Rehab Hospital for Resident #19 dated [DATE], revealed Norco 7XXX, d+[DATE] mg (Hydrocodone) was ordered every 6 hours as needed for pain (pain scale ,d+[DATE]). Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #19's blister pill pack of Hydrocodone-Acetaminophen 7XXX,d+[DATE] mg, a Schedule II controlled substance, with date not visible, was found in LPN M's possession. There were 4 of 12 Hydrocodone-Acetaminophen tablets remaining in the blister pack. f. Review of the closed medical record revealed Resident #20 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Sepsis, Diabetes, Hypothyroidism, Anxiety, Insomnia. Review of the physician's order for Resident #20 dated [DATE], revealed two capsules of Gabapentin 300 mg (for a total of 600 mg) were ordered three times a day for neuropathy. The order was discontinued [DATE]. Review of the physician's order for Resident #20 dated [DATE], revealed Gabapentin 100 MG three times a day. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #20's Gabapentin 600 mg, a Schedule V controlled substance, card 1 of 6, dated [DATE], was found in LPN M's possession. There were 0 of 30 Gabapentin capsules remaining in the blister pack. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #20 ' s Gabapentin 600 mg, a Schedule V controlled substance, card 2 of 6, dated [DATE], was found in LPN M's possession. 50 of 60 Gabapentin capsules remained in the blister pack. g. Review of the closed medical record revealed Resident #21 was admitted to the facility on [DATE], with diagnoses including Anxiety, Chronic Obstructive, Depression and Muscle Weakness. Review of the physician orders for Resident #21 dated [DATE], revealed Lorazepam 0.5 mg was ordered every 8 hours as needed for anxiety for 14 days. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #21's blister pack for Lorazepam 0.5 mg, a Schedule IV controlled substance, dated [DATE], was found in LPN M's possession. There were 0 of 20 Lorazepam tablets remaining in the blister pack. h. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Diabetes, Dementia, Anxiety, and Chronic Kidney Disease Stage 4. Review of the physician orders for Resident #22 dated [DATE], revealed Clonazepam 0.5 mg was ordered every 24 hours for anxiety. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #22's blister pack for Clonazepam 0.5 mg, a Schedule IV controlled substance, dated [DATE], was found in LPN M's possession. There were 0 of 14 Clonazepam tablets remaining in the blister pack. i. Review of the closed medical record revealed Resident #23 was admitted to the facility on [DATE], with diagnoses including Acquired Absence of Right Leg Above Knee (above the knee amputation), Anxiety, Personal History of Malignant Neoplasm of Uterus, and Diabetes. Review of the physician's orders dated [DATE], revealed Ativan (Lorazepam medication given for anxiety) 0. 5 mg was ordered 3 times every week on Monday, Wednesday, and Friday for anxiety disorder. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #23' s blister pack for Lorazepam 0.5 mg, a Schedule IV controlled substance, dated [DATE], was found in LPN M's possession. 0 of 12 Lorazepam tablets remained in the blister pack. j. Review of the closed medical records revealed Resident #25 was admitted to the facility on [DATE], with diagnoses including Diabetes, Cirrhosis of Liver, Anxiety, Insomnia, and Gout. Review of the physician orders for Resident #25 dated [DATE], revealed Gabapentin 300 mg was ordered two times a day for seizures. Review of the Law Enforcement investigation of the drug diversion by LPN M, revealed Resident #25's blister pack for Gabapentin 300 mg, a Schedule IV controlled substance, dated [DATE], was found in LPN M's possession. 2 of 30 Gabapentin capsules remained in the blister pack. Review of the physician s order for Resident #25 dated [DATE], revealed Alprazolam 0.5 mg was ordered every 8 hours as needed for anxious behavior. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #25's blister pack for Alprazolam 0.5 mg, a Schedule IV controlled substance, dated [DATE], was found in LPN M's possession. 0 of 28 Lorazepam tablets remained in the blister pack. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #25's blister pack for Alprazolam 0.5 mg, a Schedule IV controlled substance, dated [DATE], was found in LPN M's possession. 0 of 42 Lorazepam tablets remained in the blister pack. k. Review of the closed medical records revealed Resident #26 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Depression, Dementia, and Senile Degeneration of Brain. Review of the physician's order for Resident #26 dated [DATE], revealed Lorazepam 0.5 mg was ordered four times a day for seizures. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #26's blister pack for Lorazepam 0.5 mg, a Schedule IV controlled substance, dated [DATE], was found in LPN M's possession. 0 of 30 Lorazepam tablets remained in the blister pack. l. Review of the medical records revealed Resident #28 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Diabetes, Cellulitis Right Lower Limb, and Cellulitis of Left Lower Limb. Review of the physician's order for Resident #28 dated [DATE], revealed Tramadol (opioid medication given for pain) 50 mg was ordered every 6 hours PRN for pain. Review of the Medication Administration Record (MAR) dated [DATE]-[DATE], revealed Resident #28 received five doses of Doxycycline (a medication given to treat bacterial infections) 100 mg. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #28's blister pack for Doxycycline 100 mg, dated [DATE], was found in LPN M ' s possession. 9 of 14 Doxycycline remained in the blister pack. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #28's blister pack for Tramadol 50 mg, a Schedule IV controlled substance, date [DATE], was found in LPN M's possession. 50 of 60 Tramadol tablets remained in the blister pack. m. Review of the closed medical record revealed Resident #30 was admitted to the facility on [DATE], with diagnoses including Fracture of Left Femur, Dementia, Anxiety, and Dementia. Review of the physician's order for Resident #30 dated [DATE], revealed Lorazepam 0.5 mg was ordered every 12 hours as needed for agitation and anxious behavior for 2 days. Review of the Law Enforcement investigation of the drug diversion by LPN M revealed Resident #30's blister pack for Lorazepam 0.5 mg, a Schedule IV controlled substance, dated [DATE], was found in LPN M's possession. 0 of 4 Lorazepam tablets remained in the blister pack. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. During an interview on [DATE] at 9:55 AM, the Director of Nursing (DON) stated, Our investigation was limited with having enough paperwork .I would have to say, yeah, she [LPN M] did [divert residents' medications] .they brought in some sheets and I reviewed them .they were all deceased residents .she [LPN M] was delegated with removing narcotics from the cart .they [residents] would expire, she took the narcotic sheet and the narcotic and I don ' t know how she was able to do it without getting caught .I was floored, devasted and angry .there was no hint of anything. The DON stated, .I delegated to a criminal unknowingly. During an observation and interview at the [Named County] Sheriff's Department on [DATE] 9:30 AM, Investigator #1 provided the Law Enforcement investigation of the drug diversion by LPN M. Investigator #1 stated that while he was talking to (Named LPN M) she told him she was on her way to work at the facility where she was a charge nurse, he observed loose pills in the floorboard of the LPN's car and initiated a search warrant, which revealed Scheduled and non-scheduled pill blister packs, some bottles of liquid medication with resident's names on them, and the Controlled Drug (substance) Record form for several residents during the search. Continued interview revealed investigators also found a bluish-green handbag inside her (LPN M's) purse with several little baggies which contained various medications, that appeared to be ready for resale. LPN M was arrested and taken into custody at that time. Investigator #1 stated a search of LPN M's home was initiated, which also revealed many more Scheduled and non-scheduled medications with names of residents from the facility. 6a. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE], with diagnoses of Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-dominant side, Vascular Dementia, Epilepsy, Depressive Disorder, Anxiety Disorder, Mood Disorder, Pseudobulbar Effect, and Psychotic Disorder with Delusions. Review of the Medication Administration Audit Report for Resident #7 dated [DATE], revealed Lacosamide (medication to control seizures) Oral Tablet 50 mg was administered to Resident #7 at 9:07 AM. Observation and interview at the B Hall medication cart on [DATE] beginning at 11:31 AM, with LPN C, revealed the CONTROLLED DRUG RECORD for Resident #7 dated 21/ (the date was not correctly filled out), revealed 7 tablets of Lacosamide were present. Review of the Lacosamide medication card for Resident #7 revealed 6 Lacosamide tablets were present, a discrepancy of 1 tablet. LPN C confirmed the discrepancy. Review of the Alprazolam medication card for Resident #7 revealed 32 Alprazolam tablets were present, a discrepancy of 1 tablet. LPN C confirmed the discrepancy. b. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Nondisplaced Intertrochanteric Fracture of Right Femur, Osteoporosis, Falls, Dementia, and Anxiety Disorder. Review of a physician's order dated [DATE], revealed an order for Percocet (Oxycodone-Acetaminophen) , d+[DATE] mg, give 1 tablet by mouth one time 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
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation and interview at the B Hall medication cart on [DATE] beginning at 11:31 AM, with LPN C, revealed the CONTROLLED DRUG RECORD for Resident #8 dated [DATE], revealed 29 tablets of Oxycodone-Acetaminophen ,d+[DATE] mg were present. Review of the medication card for Resident #8's Oxycodone-Acetaminophen, revealed 28 Oxycodone-Acetaminophen tablets were present, a discrepancy of 1 tablet. LPN C confirmed the discrepancy. c. Review of the medical records revealed Resident #13 was admitted to the facility on [DATE], with diagnoses including Diabetes, Dependence on Renal Dialysis, Hypothyroidism, Anxiety, Bipolar Disorder, and Insomnia. Review of the physician s order for Resident #13 dated [DATE], revealed Norco (Hydrocodone-Acetaminophen) 7XXX,d+[DATE] mg, give 1 tablet by mouth 4 times a day. Observation and interview at the B Hall medication cart on [DATE] beginning at 11:31 AM, with LPN C, revealed the CONTROLLED DRUG RECORD for Resident #13 dated [DATE], revealed 10 Hydrocodone-Acetaminophen 7XXX,d+[DATE] mg tablets were present. Review of the Hydrocodone-Acetaminophen medication card for Resident #13 revealed 9 Hydrocodone-Acetaminophen tablets were present, a discrepancy of 1 tablet. LPN C confirmed the discrepancy. d. Review of the medical records revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Diabetes, Dementia, Anxiety, and Chronic Kidney Disease Stage 4. Review of the physician's order for Resident #22 dated [DATE], revealed Lorazepam 0.5 mg, give 1 tablet by mouth two times a day for anxiety. Observation and interview at the B Hall medication cart on [DATE] beginning at 11:31 AM, with LPN C, revealed the CONTROLLED DRUG RECORD for Resident #22 dated [DATE], revealed 18 Lorazepam 0.5 mg tablets were present. Review of the Lorazepam medication card for Resident #22 revealed 17 Lorazepam tablets were present, a discrepancy of 1 tablet. LPN C confirmed the discrepancy. e. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE], with diagnoses including Traumatic Spinal Cord Dysfunction, Quadriplegia, Anxiety, and Depression. Review of the physician's order for Resident #27 dated [DATE], revealed an order for Hydrocodone-Acetaminophen ,d+[DATE] mg by mouth every 6 hours as needed for pain. Observation and interview at the C Hall medication cart on [DATE] beginning at 11:23 AM, revealed Licensed Practical Nurse (LPN) B was asked to review Resident #27's controlled substance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37532 Based on policy review, American Heart Association website: www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure, medical record review, and interview, the facility failed to ensure residents were free of significant medication errors for 1 of 5 (Resident #13) sampled residents reviewed for medication administration. The findings include: 1. Review of the Administration of Drugs, policy dated April 2022, revealed . Drugs will be administered in a timely manner and as prescribed by the resident's attending physician or the Center's Medical Directo .Drugs must be administered in accordance with the written orders of the attending physicia . 2. Review of the American Heart Association website: www.heart.org/en/health-topics/high-blood-pressure/the-facts-about-high-blood-pressure revealed the following Blood Pressure Categories: a. Normal systolic (upper number) is less than 120 millimeters of mercury (mm Hg) and normal diastolic (lower number) is less than 80 mm Hg. b. Elevated blood pressure is 120-129 mm Hg systolic and elevated diastolic is less than 80 mm Hg. c. High Blood Pressure (Stage 1) is 130-139 mm Hg systolic or 80-89 mm Hg diastolic. d. High Blood Pressure (Stage 2) is 140 mm Hg or higher systolic or 90 mm Hg or higher diastolic. c. Hypertensive Crisis is higher than 180 mm Hg systolic and/or higher than 120 mm Hg diastolic. 3. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE], with diagnoses including Diabetes, Dependence on Renal Dialysis, Hypothyroidism, Anxiety, Bipolar Disorder, and Insomnia. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the Resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #13 was cognitively intact. Review of the Nurse's Note dated 1/29/2025 at 5:03 PM, revealed Resident #13 returned from dialysis with a prescription for Midodrine (Medication used to raise blood pressure) 5 mg by mouth on Monday, Wednesday, and Friday, 30 minutes before dialysis. Review of the physician's order for Resident #13 dated 1/29/2025, revealed an order for Midodrine Hydrochloride Oral Tablet 5 milligram (MG) by mouth every Monday, Wednesday, and Friday related to Dependence on Renal Dialysis, give 30 minutes prior to dialysis on Monday, Wednesday, and Friday. Review of the Black Box Warning for Midodrine revealed, midodrine can cause marked elevation of supine (lying down position) blood pressure . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the February 2025 Medication Administration Record (MAR) revealed Midodrine was administered two times a day on Monday, Wednesday, and Friday, instead of the ordered one time a day on Monday, Wednesday, and Friday. Review of the March 2025 Medication Administration Record (MAR) revealed Midodrine was administered two times a day on Monday, Wednesday, and Friday from 3/3/2025 through 3/24/2025. Review of the Vital Signs Summary on Friday, 3/7/2025 at 7:33 PM, revealed Resident #13's blood pressure was elevated at 177/95. There was no documentation to show the elevated blood pressure was re-checked. Review of the Medication Admin (Administration) Audit Report dated 3/7/2025, revealed Midodrine 5 mg was administered at 8:25 PM, less than an hour after Resident #13's blood pressure was 177/95. During an interview on 3/26/2025 at 3:32 PM, the Director of Nursing (DON) was asked to review Resident #13's medical record. The DON was asked when Midodrine should be administered. The DON stated 30 minutes prior to dialysis. The DON was asked if Midodrine should be administered twice a day on dialysis days. The DON stated, No. The DON confirmed the order for Midodrine was transcribed incorrectly and scheduled in error for two times a day instead of one time a day on dialysis days. During an interview on 3/27/2025 at 1:52 PM, Nurse Practitioner (NP) H confirmed she instructed Licensed Practical Nurse (LPN L) to enter an order for Midodrine but did not notice the order was entered incorrectly (twice a day on dialysis days). NP H stated, .I will take all the blame . NP H was asked if she would expect a blood pressure of 177/95 to be re-checked. NP H stated, I would.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37532 Based on policy review, document review, medical record review, Law Enforcement Investigation review, observation, and interview, the Administration failed to assure the provision of appropriate fiscal resources and personnel to meet the needs of the residents. Administration failed to ensure residents' medications were timely and accurately reconciled and free of misappropriation, failed to ensure competent nursing staff documented controlled substances when administered and administered medications per the physician's order and the facility's medication schedule; and failed to ensure available medications weren't expired. The findings include: 1. Review of the undated policy titled, Administration revealed, .It is the policy of the facility to provide care and services related to Administration in accordance to state and Federal regulation .The Administration of the facility will ensure the following .1. Administration 2. License/Comply with Fed [Federal] /State/Local Law/Professional Standards .5. Staff Qualifications 6. Use of Outside Resources .Resident Records-Identifiable Information . Review of the facility policy titled, Abuse Prevention Policy, reviewed [DATE], revealed .The resident has the right to be free from .misappropriation of property .Misappropriation of Resident Property .means the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent .Administrator will review investigational findings to determine appropriate corrective, remedial, or disciplinary actions to occur with accordance with applicable local, state or federal law. Administrator will review outcome in monthly continuous quality Improvement meeting . appropriate follow up and monitoring. Review of the facility policy titled, Controlled Substances revised ,d+[DATE], .The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications .Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on premises .The director of nursing services maintains a set of back-up keys for all medication storage areas including keys to controlled substance containers .Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift .Upon disposition . Medications returned to the pharmacy are recorded and signed by the director of nursing (or designee) and the receiving pharmacy .Policies and procedures for monitoring controlled medication to prevent loss, diversion .are periodically reviewed and updated by the director of nursing services and the consultant pharmacist . Review of the undated facility policy titled, Nursing Services, General, revealed .It is the policy of the facility to provide care and services related to Nursing Services in accordance to State and Federal regulation .This policy will include .Competent Nursing Staff . Review of the facility policy titled, Administration of Drugs, dated ,d+[DATE], revealed .Drugs will be administered in a timely manner and as prescribed by the resident's attending physician or the Center's Medical Director .Unless otherwise specified by the resident's attending physician, routine drugs should be administered as scheduled . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, Pharmacy Services DISCARDING AND DESTROYING MEDICATIONS, reviewed ,d+[DATE], revealed .Medication will be disposed of in accordance with federal, state and local regulations governing management of .controlled substances . Review of the facility policy titled, Charting Errors and Omissions, revised ,d+[DATE], revealed .Accurate medical records shall be maintained by this facility . 2. Review of the undated job description titled, Administrator, revealed .The primary purpose of your job position is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to assure that the highest degree of quality of care can be provided to our residents at all times .Duties and Responsibilities .Plan, develop, organize, implement, evaluate and direct the facility's programs and activities in accordance with guidelines issued by the governing board. Develop and maintain written policies and procedures and professional standards of practice that govern the operation of the facility .Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed .Consult with department directors concerning the operation of their departments to assist in eliminating/correcting problem areas, and/or improvement of services .Ensure that an adequate number of appropriately trained licensed professional and non-licensed personnel are on duty at all times to meet the needs of the residents . Review and check competence of work force and make necessary adjustments/corrections as required or that may become necessary . Review of the undated job description titled Director of Nursing Services, revealed .The primary purpose of your job position is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines and regulations that govern our facility .to ensure that the highest degree of quality care is maintained at all times As Director of Nursing Services, you are delegated the administrative authority, responsibility, and accountability necessary for carrying out your assigned duties .Develop, implement, and maintain an ongoing quality assurance program for the nursing service's department .Assist the Quality Assessment & Assurance committee in developing and implementing appropriate plans of action to correct identified deficiencies .Assist the Pharmaceutical Services Committee in developing, maintaining, implementing, and periodically updating written policies and procedures for the administration, storage, and control of medications and supplies . Delegate to nursing service supervisory personnel the administrative authority, responsibility, and accountability necessary to perform their assigned duties . Make daily rounds of the nursing service department to ensure that all nursing service personnel are performing their work assignments in accordance with acceptable nursing standards .Monitor medication passes and treatment schedules to ensure that medications are being administered as ordered and that treatments are provided as scheduled .Ensure that residents who are unable to call for help are checked frequently .Assist the Safety officer in developing safety standards for the nursing service department Ensure that a stock level of medications .is maintained on premises at all times to adequately meet the needs of the resident . Assist in the development of preliminary and comprehensive assessments of the nursing needs of each resident. Develop a written plan of care (preliminary and comprehensive) for each resident that identifies the problems/needs of the resident, indicates the care to be given, goals to be accomplished, and which professional services is responsible for each element of care . Report suspected or known incidence of fraud .Report and investigate all allegations of resident abuse and/or misappropriation of resident property . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The facility Administration failed to ensure Residents #13, #14, #15, #18, #19, #20, #21, #22, #23, #25, #26, #28, and #30 were free from misappropriation of resident property when Licensed Practical Nurse (LPN) M, diverted resident medications from [DATE] through [DATE]. The facility Administration failed to identify the misappropriation until notified by Law Enforcement Officials on [DATE]. During an interview on [DATE] at 10:17 AM, the DON was asked how the facility was made aware of the allegation of the drug diversion by LPN M. The DON stated, When they came, I think the first to come in was the District Attorney's office of drug enforcement, they came in that morning [[DATE]]and that's how I was made aware. The DON confirmed the facility did not identify the residents' medications were missing prior to notification by the authorities. The DON was asked did you identify that the controlled drug record sheet was missing on any of the residents or medications prior to being notified by the authorities. The DON stated, No. The DON was asked who provided oversight to ensure drugs were not diverted. The DON stated, Me, I have to take responsibility . During an interview on [DATE] at 3:15 PM, the Medical Director (MD) confirmed he was made aware of the allegation of drug diversion by LPN M when the District Attorney came to the building, and they asked to speak to him. The MD was asked as the Medical Director, did he expect the facility to have systems and processes in place to track and reconcile controlled substances. The MD stated, Yes. Refer to F602 4. The facility Administration facility failed to ensure staff provided appropriate pain management consistent with professional standards of practice for Resident #9 and #17 and a safe environment to prevent accidents for Resident #17. a. Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Dementia, Anxiety, Periprosthetic Fracture Around Internal Prosthetic Hip Joint, and Pain in Right Knee. Resident #9's Minimum Data Set (MDS) assessment dated [DATE], revealed the Resident was rarely understood, exhibited short-term and long-term memory problems, and was assessed by staff with severe cognitive impairment. On [DATE] at 1:15 AM, Resident #9 sustained an unwitnessed fall, and later at 9:15 AM, Resident #9 began to exhibit verbal complaints and nonverbal cues of intense pain, hollering out when her right leg was moved, grimacing, and guarding her right hip and femur (thigh bone). The practitioner was not immediately notified of Resident #9's pain and the Resident did not receive pain medication. An x-ray was ordered at 11:31 AM and was obtained approximately 2 hours later at 1:32 PM. The x-ray revealed Resident #9 suffered a periprosthetic fracture (fracture that occurs around or near an orthopedic implant). Resident #9 was transferred to the hospital at approximately 3:40 PM. Resident #9 did not receive pain medication to address her pain prior to leaving the facility. b. Review of the medical record revealed Resident #17 was readmitted to the facility on [DATE], following hospital discharge with diagnoses that included a right below the knee amputation on [DATE]. On [DATE], Resident #17's physician orders included Hydrocodone every 6 hours as needed for a moderate pain level of ,d+[DATE] and Ibuprofen 800 milligrams (mg) every 8 hours as needed for a mild pain level of , d+[DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission assessment dated [DATE] at 6:30 PM, revealed Resident #17 was experiencing pain rated as 5, which frequently caused difficulty sleeping and led to limitations of day-to-day activities. Resident #17 was severely cognitively impaired and dependent upon staff for assistance with all aspects of care. Resident #17 was experiencing uncontrolled pain as evidenced by the Resident's restlessness and trembling of the extremity. Resident #17 developed a new behavior of climbing out of bed on [DATE] and on [DATE]. Resident #17 sustained an unwitnessed fall with head injury, was transferred to the hospital and diagnosed with subarachnoid hemorrhage and a periorbital fracture. The facility failed to have a system in place to assess pain of residents with cognitive impairment and appropriately address the pain. c. During an interview on [DATE] at 9:41 AM, the DON confirmed Resident #17 did not receive Hydrocodone as ordered by the physician for pain rated 4 or greater. During an interview on [DATE] at 3:43 PM, the DON reviewed the orders from the hospital for Resident #17 that documented to pick up the ordered Hydrocodone at a local pharmacy in front of the facility. The DON stated, I would have said, whoa, I could have the family go get it and use it .she [LPN D] could have called me, and I could have given her direction .something would have happened, even if I called a Nurse Practitioner .she could have put in something [for pain]. They call me for a million things .night and day, but they didn't call me for this. The DON stated, I found out Monday when she went out. During an interview on [DATE] at 5:20 PM, when the Immediate Jeopardy template for Pain Management was presented to the Administrator and DON, the Administrator was asked was she aware of the issue with Resident #17 not receiving Hydrocodone for pain from [DATE]-[DATE]. The Administrator stated she had just been made aware when she returned from her trip (was not in the facility during the survey from [DATE] through [DATE] due to a pre-planned trip). During an interview on [DATE] at 1:33 PM, the DON confirmed Resident #9 experienced a fall with periprosthetic femur fracture, did not receive pain medication on [DATE], and the nursing staff should have called the Nurse Practitioner (NP) to get an order for pain medication. Refer to F689 and F697 5. The facility Administration failed to ensure the facility had a system of recording, accurate reconciliation, and accounting for all controlled medications, failed to promptly identify diversion of controlled substances, failed to provide medications according to physician orders and the facility's medication schedule, and failed to ensure controlled substances were in date and no discrepancies were identified for Residents #8, #9, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, #24, #25, #26, #27,# 28, #29, #30, #31, #32, #33, #34, #35, #36, #37, #38, #41, and #42 reviewed for drug diversion, controlled substance reconciliation, and administration of medications. During a telephone interview on [DATE] at 12:15 PM, the Administrator was asked how the facility reconciled controlled substances prior to [DATE], to ensure that all medications delivered to the facility were handled properly and accounted for. The Administrator was unable to answer the question and stated, That would be a DON [Director of Nursing] question . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Administrator was asked if she was aware that LPN M had unlimited access to controlled substances without having to have a second nurse to sign with her. The Administrator stated, .No, I was not .I thought it was always two nurses . The Administrator was asked if, as the Administrator, she expected that someone was tracking the controlled substances. The Administrator stated, .Yes, I just expect that to be the DON's responsibility to make sure those [controlled] substances are safe . During an interview on [DATE] at 3:43 PM, the DON was asked when the narcotic E-kit should be reconciled if a medication is taken out of it. The DON stated, When it's taken out. The DON confirmed she identified the narcotic E-kit on the C Hall Medication Cart was expired on [DATE] when she audited the cart at the time of the drug diversion by Licensed Practical Nurse (LPN) M. The DON stated, .I have since it expired been trying to get it in here . During an interview on [DATE] at 3:38 PM, the DON acknowledged the facility was having issues with medications being administered as ordered. The DON stated medication administration was being spotty, and they were trying to conduct additional training for agency staff. The DON acknowledged nursing staff failed to follow the education and training related to controlled substance documentation that was provided after the drug diversion was identified in [DATE], when the controlled substances were not signed out when administered on [DATE]. The DON acknowledged this was a staff performance issue, rather than an education issue. Refer to F726 and F755

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37532 Based on policy review, medical record review, and interview, the facility failed to maintain accurate medical records related to medication administration for 6 of 6 (Resident #6, 9, 13, 16, 24, and 38) sampled residents reviewed for medication administration. The findings included: 1. Review of the facility policy titled, Charting and Documentation, revised 7/2017, revealed .All services provided to the resident .or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record .The following information is to be documented in the resident medical record .Medications administered . Review of the facility policy titled, Administration of Drugs, dated 4/2022, revealed .Drugs will be administered in a timely manner and as prescribed by the resident's attending physician or the Center's Medical Director .Unless otherwise specified by the resident's attending physician, routine drugs should be administered as scheduled .The nurse administering the drug must record such information on the residents eMAR [electronic Medication Administration Record] .must electronically sign the resident's eMAR immediately after administration . Review of the facility policy titled, Charting Errors and Omissions, revised 12/2022, revealed .Accurate medical records shall be maintained by this facility .Late entries in the medical record shall be dated at the time of entry and noted as a late entry . 2. Review of the medical record revealed Resident #6 was readmitted on [DATE], with diagnoses of Parkinson's Disease, Contracture of ankle, and muscle spasms. Review of the Minimum Data Set (MDS) dated [DATE], revealed Resident #6 was cognitively intact and required use of a wheelchair for mobility. Review of the physician's orders dated 1/2/2025 for Resident #6 revealed Carbidopa Levodopa ER (extended release) oral tablet 25-100 milligram (mg) give 1 tablet by mouth every three hours for Parkinson's Disease, Entacapone 200 mg give 1 tablet by mouth every 3 hours for Parkinson's Disease, Ropinirole Hydrochloride (HCL) 0.5 mg give 1 tablet by mouth 3 times a day for Parkinson's, Tizanidine HCl 4mg give 1 tablet by mouth 3 times a day for Contracture, and Gabapentin 800 mg give 1 tablet by mouth 3 times a day for Parkinson's Disease. Review of the physician's orders dated 2/18/2025, Resident #6 Carvidopa 50-200 mg give 1 tablet by mouth four times a day for Parkinson's Disease, Diazepam 2mg give 1 tablet by mouth three times a day for Anxiety disorder and muscle spasms. Review of the Medication Admin (Administration) Audit Report, which indicated the actual time medications were documented as being administered, dated 3/14/2025 revealed the following medications were not documented as being administered accurately: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Ropinirole HCl 0.5 mg scheduled for 5:00 AM was documented as administered at 9:24 AM. The Tizanidine HCl 4 mg scheduled for 5:00 AM was documented as administered at 9:24 AM. The Gabapentin 800 mg scheduled for 6:00 AM was documented as administered at 9:24 AM. The Entacapone 200 mg give 1 tablet scheduled for 6:00 AM was documented as administered at 9:24 AM. The Carbidopa- Levodopa 25-100 mg dose scheduled for 6:00 AM was documented as administered at 9:24 AM. The Diazepam 2 mg scheduled for 6:00 AM was documented as administered at 9:24 AM. The Ropinirole HCl 0.5 mg scheduled for 9:00 PM was documented as administered at 11:34 PM. The Tizanidine HCl 4 mg scheduled for 9:00 PM was documented as administered at 11:33 PM. The Entacapone 200 mg scheduled for 9:00 PM was documented as administered at 11:33 PM. The Carbidopa-Levodopa 25-100 mg scheduled for 9:00 PM was documented as administered at 11:33 PM. During an interview on 3/18/2025 at 2:26 PM, Resident #6 stated on Friday night 3/14/2025, the nurse did not give him his Parkinson's medicine as scheduled. Resident #6 stated, This problem comes and goes, depending on the number of agency nurses working. During interview on 3/20/25 12:05 PM, the Director of Nursing (DON) confirmed the medication administration audit revealed Resident #6's medication was not administered as scheduled per the physician order and/or the medication administration was not documented timely and accurately. 3. Review of the medical records revealed Resident #9 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Dementia, Diabetes, Anxiety, Periprosthetic Fracture Around Internal Prosthetic Hip Joint, and Pain in Right Knee. Review of a physician's order for Resident #9 dated 2/6/2025, revealed an order for Acetaminophen (for minor aches and pains) 325 mg, give 3 tablets by mouth two times a day. Review of the fall Incident Report dated 2/21/2025 at 1:15 AM, revealed Resident #9 sustained an unwitnessed fall. Review of the undated facility document titled MED (Medication) PASS TIME FRAMES revealed medications ordered two times a day should be administered from 7:00 AM-10:00 AM for the morning dose and 7:00 PM-10:00 PM for the evening dose. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Medication Admin Record (MAR) for Resident #9 dated 2/21/2025, revealed a 6 (indicated the resident was hospitalized) was documented in the box where the 7:00 AM to 10:00 AM dose of Acetaminophen should have been documented. Resident #9 was not transferred to the hospital until approximately 3:41 PM. Continued review revealed the MAR did not reflect documentation that Resident #9 received the Acetaminophen. Review of the E-INTERACT FORM dated 2/21/2025, revealed Resident #9 was transferred to the hospital at 3:41 PM. During a telephone interview on 3/27/2025 beginning at 2:10 PM, Licensed Praqctical Nurse (LPN) was asked about her documentation of Acetaminophen on the Medication Administration Record (MAR) that documented a 6 which indicated the resident was hospitalized , and asked did that mean the medication was not administered. LPN L stated, I guess not. LPN L stated she did not remember what time Resident #9 was transferred to the hospital. 4. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including Diabetes, Dependence on Renal Dialysis, Hypothyroidism, Anxiety, Bipolar Disorder, and Insomnia. a. Review of the physician's order for Resident #13 dated 2/6/2025, revealed the following: Insulin Lispro (fast-acting insulin to lower blood glucose) 100 Units/ML, inject per sliding scale before meals for blood sugar (glucose) levels of: 71 - 150 mg/dL = 0 units 151 - 200 mg/dL = 2 units 201 - 250 mg/dL = 4 units 251 - 300 mg/dL = 6 units 301 - 350 mg/dL = 8 units 351 - 400 mg/dL= 10 units 401 mg/dL or above = 10 units recheck in one hour if blood sugar (glucose) has not gone down, notify the Nurse Practitioner (NP). Continued review revealed Norco (Hydrocodone-Acetaminophen) 7.5-325 mg, give 1 tablet by mouth four times a day for pain, Montelukast Sodium 10 mg, give 1 tablet by mouth one time a day for allergies, Ezetimibe 10 mg, give 1 tablet by mouth one time a day for Hyperlipidemia, Fluticasone Propionate Nasal Suspension 50 micrograms/actuation (mcg/act), 1 spray alternating nostrils two times a day for Allergic Rhinitis, and Sennosides-Docusate (Senna-S) 8.6-50 mg, give 2 tablets by mouth one time a say for Constipation. b. Review of the MAR for Resident #13 dated 2/1/2025-2/28/2025, revealed the following medications were documented as being administered timely: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/2025 at 7:30 AM, Resident #13's blood glucose (sugar) was 233 milligrams per deciliter (mg/dL) and LPN L documented she administered 4 units of Lispro Insulin at 7:30 AM. On 2/26/2025 at 12:00 PM, Resident #13's blood glucose was 264 mg/dL and LPN L documented she administered 6 units of Lispro Insulin at 12:00 PM. On 2/26/2025 at 11:00 AM, LPN L documented that she administered Resident #13's Norco. Review of the Medication Admin Audit Report, which indicated the actual time medications were documented as being administered, dated 2/25/2025-2/27/2025 revealed the following medications were not documented as being administered accurately: The Lispro Insulin scheduled on 2/26/2025 at 7:30 AM was documented as administered at 2:20 PM. The Norco 7.5-325 mg scheduled on 2/26/2025 at 11:00 AM was documented as administered at 2:20 PM. The Lispro Insulin scheduled on 2/26/2025 at 12:00 PM was documented as administered at 2:21 PM. The Buspirone 10 mg scheduled on 2/27/2025 at 7:00 PM-10:00 PM was documented as administered on 2/28/2025 at 1:51 AM. The Montelukast Sodium 10 mg scheduled on 2/27/2025 at 7:00 PM-10:00 PM was documented as administered on 2/28/2025 at 1:51 AM. The Ezetimibe 10 mg scheduled on 2/27/2025 at 7:00 PM-10:00 PM was documented as administered on 2/28/2025 at 1:52 AM. The Fluticasone Propionate Nasal Spray scheduled on 2/27/2025 at 7:00 PM-10:00 PM was documented as administered on 2/28/2025 at 1:52 AM. The Senna-S 8.6-50 mg scheduled on 2/27/2025 at 7:00 PM-10:00 PM was documented as administered on 2/28/2025 at 1:53 AM. Review of the MAR revealed the medications were administered timely, but review of the Medication Admin Audit Report revealed the medications were actually not accurately documented as administered timely. Observation and interview in the Resident's room on 3/13/2025 at 9:20 AM, revealed Resident #13 was in bed and wearing oxygen. Resident #13 stated a night nurse (Named LPN Q) said he gave her medications while she was asleep, but she told him she couldn't take medications while she slept. Resident #13 stated, . come to find out the next morning there was a lot of people that didn't get their medication so he's not coming back . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/26/2025 at 12:46 PM, LPN L stated medication should be administered within an hour before and an hour after the time it was scheduled. LPN L reviewed the Medication Admin Audit Report and stated she gave Resident #13's 7:30 AM dose of Lispro Insulin before breakfast. LPN L stated, I know because that's when I go down the hall and administer .sometimes there's just so much going on with that many patients it's hard to get it signed out. LPN L stated she administered Resident #13's 12:00 PM Lispro and Norco right before the Resident left for Dialysis which was around 11:00 AM. When asked about the documentation that showed Resident #13 received her 7:30 AM at 2:20 PM and 12:00 PM dose of Lispro Insulin at 2:21 PM, LPN L stated, That's probably just when I was able to chart it [Lispro Insulin and Norco] . 5. Review of the medical records revealed Resident #16 was admitted to the facility on [DATE], with diagnoses including Diabetes, Hypothyroidism, Gout and Cellulitis of Right Lower Limb. Review of the physician's orders for Resident #16 dated 3/6/2025 revealed Levothyroxine Sodium Tablet 137 micrograms (MCG) Give 1 tablet by mouth one time a day for Hypothyroidism and Furosemide Tablet 20 mg Give 1 tablet by mouth one time a day for edema. Review of the quarterly MDS assessment dated [DATE] revealed resident had a BIMS score of 15, which indicated Resident #16 was cognitively intact. Review of the Medication Admin Audit Report, which indicated the actual time medications were documented as being administered, dated 3/14/2025 revealed the following medications were not documented as being administered accurately: The Levothyroxine Sodium 137 MCG Give 1 tablet scheduled at 4:00 AM was documented as administered at 1:06 PM. The Furosemide 20 mg Give 1 tablet scheduled at 5:00 AM was documented as administered on 3/14/2025 at 1:06 PM. Observation and interview in the Resident's room on 3/13/2025 at 9:34 AM, revealed Resident #16 was in bed. Resident #16 stated there were times she did not receive her medications as scheduled especially on the night shift and she would get the medications when the day shift nurse arrived. During an interview on 3/26/2025 at 3:38 PM, the DON confirmed Resident #16's Levothyroxine that was due at 4:00 AM and the Furosemide that was due at 5:00 AM were documented as administered at 1:06 PM. The DON stated, [Named LPN C] comes at 7 [7:00] AM and gave the meds that were due at 4 [4:00] and 5 [5:00] am because they were not administered by either Agency [an agency nurse] or [Named LPN Q], a prn nurse. The DON stated, .it's [medication administration] being spotty and we're trying to get every agency person in here for additional training and the ones who are not performing I'm not letting them come back. 6. Review of the medical records revealed Resident #24 was admitted to the facility on [DATE], with diagnoses including Diabetes, Paraplegia, Schizophrenia, Narcolepsy, Insomnia, and Anxiety. Review of the quarterly MDS assessment dated [DATE], revealed resident had a BIMS score of 15, which indicated Resident #24 was cognitively intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the physician's orders for Resident #24 dated 3/6/2025, revealed Simethicone 125 mg give 1 tablet by mouth before meals and at bedtime for heartburn, Tamsulosin HCL 0.4 mg give 2 capsules by mouth at bedtime for enlarged prostate, Risperdal 1 mg give one tablet by mouth at bedtime for Schizophrenia, Gabapentin 600 mg give 1 tablet by mouth three times a day for Polyarthritis, Clonazepam 1 mg give 1.5 tablets by mouth at bedtime for Anxiety, and Mesalamine Rectal Suppository 1000 mg, insert 1 suppository rectally at bedtime for Constipation. Review of the Medication Admin Audit Report, which indicated the actual time medications were documented as being administered, dated 3/14/2025-3/16/2025 revealed the following medications were not documented as being administered accurately: The Simethicone 125 mg scheduled at 9:00 PM was documented as administered on 3/15/2025 at 12:01 AM. The Tamsulosin HCL 0.4 mg scheduled at 9:00 PM was documented as administered on 3/15/2025 at 12:01 AM. The Risperdal 1 mg scheduled at 9:00 PM was documented as administered on 3/15/2025 at 12:01 AM. The Gabapentin 600 mg scheduled at 9:00 PM was documented as administered on 3/15/2025 at 12:01 AM. The Clonazepam 1 mg scheduled at 9:00 PM was documented as administered on 3/15/2025 at 12:01 AM. The Mesalamine Suppository 1000 mg scheduled for 3/14/2025 at 9:00 PM, was documented as administered on 3/15/2025 at 12:01 AM. 7. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE] with diagnoses including Dementia, Diabetes, Bipolar Disorder, Schizophrenia, Osteoarthritis, and Depression. Review of the annual MDS assessment dated [DATE] revealed Resident #38 was cognitively intact. Review of the physician's orders for Resident 38 dated 3/6/2025, revealed Acetaminophen 650 MG give 2 tablets by mouth three times a day, Gabapentin (to treat seizures and nerve pain) 800 MG give 1 tablet by mouth three times a day, Ziprasidone (to treat Schizophrenia) 20 MG give 1 capsule by mouth at bedtime, Ziprasidone 80 MG, give 1 capsule by mouth at bedtime, and Lamictal (to treat seizures and bipolar disorder) 200 MG give one tablet by mouth at bedtime. Review of the Medication Admin Audit Report, which indicated the actual time medications were documented as being administered, dated 3/15/2025 revealed the following medications were not documented as being administered accurately: The Acetaminophen 650 mg scheduled at 9:00 PM was documented as administered on 3/16/2025 at 1:44 AM. The Lamictal 200 mg scheduled at 9:00 PM was documented as administered on 3/16/2025 at 2:13 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445425	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Millington Healthcare Center	5081 Easley Avenue Millington, TN 38053

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Gabapentin 800 mg scheduled at 9:00 PM was documented as administered on 3/16/2025 at 2:14 AM. The Ziprasidone 20 mg scheduled at 9:00 PM was documented as administered on 3/16/2025 at 2:16 AM. The Ziprasidone 80 mg scheduled at 9:00 PM was documented as administered on 3/16/2025 at 2:16 AM. Observation and interview on 3/17/2025 at 12:20 PM, revealed Resident #38 sitting in her wheelchair in her room and the Resident stated, .didn't get our meds last night till 2:30 the next morning .agency nurse she didn't know what she was doing .