STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	02/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAPTERS LIVING OF GREENSBURG	1034 CROWN POINTE BLVD, GREENSBURG, , 47240

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes 465904, 466553, and 466185. Intake 465904 - State Residential Findings related to the allegations are cited at R0064 and R0298. Intake 466553 - No deficiencies related to the allegations were cited. Intake 466185 - No deficiencies related to the allegations were cited. Unrelated deficiencies cited. Survey dates: February 02 and 03, 2026. Facility number: 011914 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5.	R 0000		

	Quality review completed on February 4, 2026.			
R 0064	Residents' Rights- Noncompliance 410 IAC 16.2-5-1.2(hh) (hh) The facility shall exercise reasonable care for the protection of residents ' property from loss and theft. The administrator or his or her designee is responsible for investigating reports of lost or stolen resident property and that the results of the investigation are reported to the resident. Based on observation, interview, and record review, the facility failed to prevent misappropriation of a resident's controlled medication for 1 of 7 residents reviewed for Resident Rights. (Resident F) Findings include: During an observation, on 02/02/26 at 12:20 P.M., Qualified Medication Aide (QMA) 3 was counting residents' controlled in the 200-Hall medication cart. Resident F had a blister pack of Xanax (an anxiety medication) 0.25 mg tablets. The tablets were oval shaped. The controlled medication count sheet indicated the resident was to have 11 tablets in the pack. The 11th tablet section had been opened and taped closed;	R 0064	With the change to electronic MAR, the pharmacy places all new orders in the system. These orders must be verified by the nurse. The DHW or designee will monitor for orders needing verified daily. An audit tool is being used to help track all monitoring and began the day we received the citation. Nursing staff is being educated on physicians orders and will be completed by all on schedule by 02/20/26 prior to their next scheduled shift. Attached is the audit tool.	

	and contained a small round white tablet that did not match the other tablets. The QMA indicated resident's medications should not have been taped back into the packages. During an interview and observation, on 02/02/26 at 12:35 P.M., the Director of Nursing (DON) indicated the resident's medications should not have been taped back into the medication packs. The 11th tablet did appear to be a different medication. She removed the tablet from the medication pack and went into another room. She returned and indicated the medication in the package was an allergy medication and not the resident's Xanax that it should have been. The clinical record for Resident F was reviewed on 02/03/2026 at 10:07 A.M. The resident's diagnosis included, but was not limited to, anxiety. The physician's order, with a start date of 09/23/2025, indicated for the resident to be administered Xanax 0.25 milligrams (mg) every day. The resident did not have a physician's order for an allergy medication which was taped in the place of the resident's Xanax.			

	The current, undated, facility policy titled, "Misappropriation of Narcotics & Narcotic Count" was provided by the Administrator on 02/03/2026. The policy indicated, "...The facility maintains strict control over all narcotics and controlled substances to prevent misappropriation, diversion, loss, or misuse. All controlled substances shall be handled, stored, administered, documented, and disposed of in accordance with Indiana regulations, federal law, and facility policy to ensure resident safety and regulatory compliance...Safeguard residents from medication errors, abuse, or neglect...prevent diversion and misuse of controlled substances...Misappropriation: The deliberate or accidental misuse, theft, diversion, or unauthorized use of a resident's medications..." The citation relates to Intake 465904. Based on observation, interview, and record review, the facility failed to prevent misappropriation of a resident's controlled medication for 1 of 7 residents reviewed for Resident Rights. (Resident F) Findings include: During an observation, on			

	02/02/26 at 12:20 P.M., Qualified Medication Aide (QMA) 3 was counting residents' controlled in the 200-Hall medication cart. Resident F had a blister pack of Xanax (an anxiety medication) 0.25 mg tablets. The tablets were oval shaped. The controlled medication count sheet indicated the resident was to have 11 tablets in the pack. The 11th tablet section had been opened and taped closed; and contained a small round white tablet that did not match the other tablets. The QMA indicated resident's medications should not have been taped back into the packages. During an interview and observation, on 02/02/26 at 12:35 P.M., the Director of Nursing (DON) indicated the resident's medications should not have been taped back into the medication packs. The 11th tablet did appear to be a different medication. She removed the tablet from the medication pack and went into another room. She returned and indicated the medication in the package was an allergy medication and not the resident's Xanax that it should have been. The clinical record for Resident F was reviewed on 02/03/2026 at 10:07 A.M. The resident's			

	diagnosis included, but was not limited to, anxiety. The physician's order, with a start date of 09/23/2025, indicated for the resident to be administered Xanax 0.25 milligrams (mg) every day. The resident did not have a physician's order for an allergy medication which was taped in the place of the resident's Xanax. The current, undated, facility policy titled, "Misappropriation of Narcotics & Narcotic Count" was provided by the Administrator on 02/03/2026. The policy indicated, "...The facility maintains strict control over all narcotics and controlled substances to prevent misappropriation, diversion, loss, or misuse. All controlled substances shall be handled, stored, administered, documented, and disposed of in accordance with Indiana regulations, federal law, and facility policy to ensure resident safety and regulatory compliance...Safeguard residents from medication errors, abuse, or neglect...prevent diversion and misuse of controlled substances...Misappropriation: The deliberate or accidental misuse, theft, diversion, or unauthorized use of a resident's			

	medications..." The citation relates to Intake 465904.			
R 0239	Health Services - Nonconformance 410 IAC 16.2-5-4(c) (c) Each facility shall choose whether or not it administers medication or provides residential nursing care, or both. These policies shall be delineated in the facility policy manual and clearly stated in the admission agreement. Based on record review and interview, the facility failed to follow a physician's order related to obtaining a resident's blood pressure and heart rate for 1 of 7 residents reviewed for Health Services. (Resident H) Findings include: The clinical record for Resident H was reviewed on 02/03/2026 at 10:45 A.M. The resident's diagnosis included, but was not limited to, Hypertension (high blood pressure). A current physician's order, with a start date of 01/09/2026, indicated the resident was to receive carvedilol (a heart medication) 25 milligrams (mg), twice a day. The medication was to be held if the resident's systolic blood pressure (SBP)	R 0239	With the change to electronic MAR, the pharmacy places all new orders in the system. These orders must be verified by the nurse. The DHW or designee will monitor for orders needing verified daily. An audit tool is being used to help track all monitoring and began the day we received the citation. Nursing staff is being educated on physicians orders and will be completed by all on schedule by 02/20/26 prior to their next scheduled shift. Attached is the audit tool. This POC applies to the 0064 deficiency as well. Orders are now in the electronic emar system and will be monitored daily by DON or designee. All nursing staff have individual access and medications are signed out electronically.	

	was less than 100 and the resident's heart rate was less than 55. The January and February 2026 weight and vital signs (v/s) documentation page located in the Medication Administration Record (MAR) indicated the resident's v/s were only taken on the following dates: - On 01/10/2025, - On 01/13/2025, - On 01/19/2025, - On 01/26/2025, and - On 02/03/2025. The clinical record lacked documentation of the resident's the blood pressure or heart rate being obtained dialy, twice a day, prior to each time the resident had taken her carvedilol 25mg tablet. During an interview, on 02/03/2025 at 11:08 A.M., Qualified Medication Aide (QMA) 4 indicated if the resident's blood pressure and heart rate weren't on the v/s sheet in the front of the MAR than the staff had not obtained it. During an interview, on 02/03/2026 at 11:16 A.M., Resident H indicated that she			

didn't take her own blood pressure or heart rate and the nurses here only check it every once in a while.

The current facility policy, titled "Chapters Living Medication Administration Policy", dated 09/17/2025, was provided by the Administrator on 02/03/2026 at 9:17 A.M. The policy indicated, "This policy outlines the procedures for safe and compliant administration of medications within the community, including self-administration by residents..."

Based on record review and interview, the facility failed to follow a physician's order related to obtaining a resident's blood pressure and heart rate for 1 of 7 residents reviewed for Health Services. (Resident H)

Findings include:

The clinical record for Resident H was reviewed on 02/03/2026 at 10:45 A.M. The resident's diagnosis included, but was not limited to, Hypertension (high blood pressure).

A current physician's order, with a start date of 01/09/2026, indicated the resident was to receive carvedilol (a heart medication) 25 milligrams (mg), twice a day. The medication was to be held if the resident's

	systolic blood pressure (SBP) was less than 100 and the resident's heart rate was less than 55. The January and February 2026 weight and vital signs (v/s) documentation page located in the Medication Administration Record (MAR) indicated the resident's v/s were only taken on the following dates: - On 01/10/2025, - On 01/13/2025, - On 01/19/2025, - On 01/26/2025, and - On 02/03/2025. The clinical record lacked documentation of the resident's the blood pressure or heart rate being obtained dialy, twice a day, prior to each time the resident had taken her carvedilol 25mg tablet. During an interview, on 02/03/2025 at 11:08 A.M., Qualified Medication Aide (QMA) 4 indicated if the resident's blood pressure and heart rate weren't on the v/s sheet in the front of the MAR than the staff had not obtained it. During an interview, on 02/03/2026 at 11:16 A.M.,			

	Resident H indicated that she didn't take her own blood pressure or heart rate and the nurses here only check it every once in a while. The current facility policy, titled "Chapters Living Medication Administration Policy", dated 09/17/2025, was provided by the Administrator on 02/03/2026 at 9:17 A.M. The policy indicated, "This policy outlines the procedures for safe and compliant administration of medications within the community, including self-administration by residents..."			
R 0295	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(a) (a) Residents who self-medicate may keep and use prescription and nonprescription medications in their unit as long as they keep them secured from other residents. Based on record review, observation, and interview, the facility failed to ensure a resident's medications were stored safely for 1 of 3 residents reviewed for self-administration of medications. (Resident D) Findings included: Resident D's record was	R 0295	All medication kept in medication carts are to be kept in packaging per pharmacy packing. No medication may be taped back into a package. All narcotics must be counted at the beginning and ending of each shift to include number of bottles/boxes etc and number of count sheets. Each must sign in/out each time for your shift on the narcotics log sheet. An audit tool is attached for this monitoring as well. Staff will be educated on medication storage as well and this will be completed by 02/20/26	

	reviewed on 02/02/2026 at 1:47 P.M. The resident's diagnosis included, but were not limited to, chronic pain syndrome. The resident self-administered their medications. The resident's current physician's orders included, but were not limited to, an open-ended order, with a start date of 11/01/2025, for hydrocodone/acetaminophen (an opiate pain medication) 10/325 milligrams. The resident could take one tablet by mouth four times a day as needed for pain. The resident's most recent medication self-administration assessment, dated 11/04/2025, indicated the resident was responsible for self-administration of her medications after the responsible party/designee filled a weekly pill dispenser. The resident's medications were to be stored in her room and in a medication box. The resident had physician's orders in place for the medications she was okay to self-administer. A notation, dated 11/26/2025, indicated the resident did not wish to allow nursing staff to administer her pain medication at that time. The resident was observed, in her room on 02/03/2026 at 1:08 P.M. The resident was sitting in her chair with her rolling walker			

	parked in front of her. The room was cluttered, with various papers, personal items, and food items stored near and around the resident. A few medication bottles were observed on the side table next to the resident and another bottle was on the floor near the resident's chair. The resident indicated something had happened with her medications. She used to just keep her bottle of pain medication in her rolling walker, under the seat. One day she lifted the seat, and the pain pills were gone. They used to come in a bottle, now they come in blister packs. She had a safe that was locked in her room and that was where she kept the blister packs of pain medicine now, she didn't keep medications in the safe before. The resident then took a multi-colored pill organizer out from under the seat of her rolling walker and indicated nursing staff filled the organizer with her daily medications weekly. In addition to that organizer, she reached around to the left side of her chair and brought out a small pill organizer that contained four or five pills. She said that was where she kept her pain pills for the week. They were PRN (as needed), and she could take one up to four times a day if she needed to. She didn't always take them four times a day, so			

	she kept the "extra" pills in the end slot of the organizer in case she needed them. There have been times in the past where a resident would wander into her room. She did not routinely lock her door. During an interview, on 02/03/2026 at 9:15 A.M., Certified Nurse Aide (CNA) 2 indicated the resident was very careless with her medications. If you went into her room, there would be medication bottles all over. A Police Report, dated 11/25/2025, was reviewed and indicated the resident reported she was prescribed hydrocodone and received 120 pills per month. The prescription was filled on 11/15/2025 by the resident's family member and the bottle was still in the packaging and stapled closed when the resident received it. The resident went to fill up her weekly medication container on 11/20/2025 and observed 26 pills to be missing. The resident was unsure of how they could have been taken, but stated staff did have access to her room. It should be noted that this was not the first incident of the resident missing medications. A similar incident occurred on 04/16/2025, when the resident reported 30 hydrocodone pills had been			

	stolen and had been missing for an extended period of time. Supplemental documentation in the report indicated the facility stated that this was an ongoing issue with the resident and they were considering no longer letting her self-administer her medications. During an interview, on 02/03/2026 at 10:10 A.M., the Administrator indicated the resident did have some missing medications several months prior to the November incident. They didn't find those pills. During an interview, on 02/03/2026 at 1:18 P.M., the Administrator indicated it would be safer if the resident's medications were kept at the Nurses' station. The facility policy indicated the resident's medications were stored properly if the resident's door was locked. If she wasn't keeping her door locked, then the medications were not stored appropriately. There used to be a resident that wandered, that was one of the reasons the resident needed to keep her door locked. She was unaware and did not know if the DON was aware that the resident kept a small pill organizer with several of her pain pills in it. The current facility policy, titled "Chapters Living Medication			

	Administration Policy", dated 09/17/2025, was provided by the Administrator on 02/03/2026 at 9:17 A.M. The policy indicated, "...Residents who are assessed to be capable of managing their medications may self-administer, provided the following conditions are met...Medications are stored securely in the resident's unit, inaccessible to others..." Based on record review, observation, and interview, the facility failed to ensure a resident's medications were stored safely for 1 of 3 residents reviewed for self-administration of medications. (Resident D) Findings included: Resident D's record was reviewed on 02/02/2026 at 1:47 P.M. The resident's diagnosis included, but were not limited to, chronic pain syndrome. The resident self-administered their medications. The resident's current physician's orders included, but were not limited to, an open-ended order, with a start date of 11/01/2025, for hydrocodone/acetaminophen (an opiate pain medication) 10/325 milligrams. The resident could take one tablet by mouth four times a day as needed for pain. The resident's most recent medication self-administration			

	assessment, dated 11/04/2025, indicated the resident was responsible for self-administration of her medications after the responsible party/designee filled a weekly pill dispenser. The resident's medications were to be stored in her room and in a medication box. The resident had physician's orders in place for the medications she was okay to self-administer. A notation, dated 11/26/2025, indicated the resident did not wish to allow nursing staff to administer her pain medication at that time. The resident was observed, in her room on 02/03/2026 at 1:08 P.M. The resident was sitting in her chair with her rolling walker parked in front of her. The room was cluttered, with various papers, personal items, and food items stored near and around the resident. A few medication bottles were observed on the side table next to the resident and another bottle was on the floor near the resident's chair. The resident indicated something had happened with her medications. She used to just keep her bottle of pain medication in her rolling walker, under the seat. One day she lifted the seat, and the pain pills were gone. They used to come in a bottle, now they come in blister packs. She had a safe			

	that was locked in her room and that was where she kept the blister packs of pain medicine now, she didn't keep medications in the safe before. The resident then took a multi-colored pill organizer out from under the seat of her rolling walker and indicated nursing staff filled the organizer with her daily medications weekly. In addition to that organizer, she reached around to the left side of her chair and brought out a small pill organizer that contained four or five pills. She said that was where she kept her pain pills for the week. They were PRN (as needed), and she could take one up to four times a day if she needed to. She didn't always take them four times a day, so she kept the "extra" pills in the end slot of the organizer in case she needed them. There have been times in the past where a resident would wander into her room. She did not routinely lock her door. During an interview, on 02/03/2026 at 9:15 A.M., Certified Nurse Aide (CNA) 2 indicated the resident was very careless with her medications. If you went into her room, there would be medication bottles all over. A Police Report, dated 11/25/2025, was reviewed and			

	indicated the resident reported she was prescribed hydrocodone and received 120 pills per month. The prescription was filled on 11/15/2025 by the resident's family member and the bottle was still in the packaging and stapled closed when the resident received it. The resident went to fill up her weekly medication container on 11/20/2025 and observed 26 pills to be missing. The resident was unsure of how they could have been taken, but stated staff did have access to her room. It should be noted that this was not the first incident of the resident missing medications. A similar incident occurred on 04/16/2025, when the resident reported 30 hydrocodone pills had been stolen and had been missing for an extended period of time. Supplemental documentation in the report indicated the facility stated that this was an ongoing issue with the resident and they were considering no longer letting her self-administer her medications. During an interview, on 02/03/2026 at 10:10 A.M., the Administrator indicated the resident did have some missing medications several months prior to the November incident. They didn't find those pills. During an interview, on			

	02/03/2026 at 1:18 P.M., the Administrator indicated it would be safer if the resident's medications were kept at the Nurses' station. The facility policy indicated the resident's medications were stored properly if the resident's door was locked. If she wasn't keeping her door locked, then the medications were not stored appropriately. There used to be a resident that wandered, that was one of the reasons the resident needed to keep her door locked. She was unaware and did not know if the DON was aware that the resident kept a small pill organizer with several of her pain pills in it. The current facility policy, titled "Chapters Living Medication Administration Policy", dated 09/17/2025, was provided by the Administrator on 02/03/2026 at 9:17 A.M. The policy indicated, "...Residents who are assessed to be capable of managing their medications may self-administer, provided the following conditions are met...Medications are stored securely in the resident's unit, inaccessible to others..."			
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear	R 0296	Due to the resident administering her own meds and these being kept in her room we have provided her as well as the others who self administer a lock box to keep in	

	written policies and procedures on medication assistance. The facility shall provide for ongoing training to ensure competence of medication staff. Based on record review and interview, the facility failed to transcribe a physician's order for 1 of 7 residents reviewed for pharmacy services. (Resident G) Findings include: The clinical record for Resident G was reviewed on 02/03/2026 at 10:16 A.M. The resident's diagnosis included, but was not limited to, pain. A Narcotic Count Book indicated the resident had a narcotic sheet for Oxycodone-APAP (acetaminophen) 5-325 milligrams (mg). The medication was signed out by staff on the following dates and times: -On 08/06/2025 at 8:00 P.M., -On 08/07/2025 at 7:20 A.M., -On 08/08/2025 at 7:50 A.M., and -On 09/16/2025 at 7:00 P.M. The August 2025 MAR (Medication Administration Record) lacked a physician's order for the resident to have been administered oxycodone		their rooms for extra safety of meds.	

	(pain) medication. The September 2025 MAR indicated the resident had a physician's order, with a start date of 08/06/2025, for the resident's Oxycodone-APAP 5-325 mg, 1 tablet every 6 hours as needed. During an interview, on 02/03/2026 at 9:50 A.M., the Director of Nursing (DON) indicated the resident's oxycodone medication was not transcribed to the MAR in August and should have been. The current facility policy titled, "Telephone Orders" was revised on 09/17/2025 and was provided by the Administrator on 02/03/2026 at 1:47 P.M. The policy indicated, "...Receiving a Telephone Order...The nurse must:...Document the order immediately...Include the specific medication, treatment, dosage, frequency, route, and reason if applicable...Documentation Requirements...All orders must be documented in the resident's clinical record or designated telephone order form...Staff Responsibilities...Licensed Nurse: Ensure accurate transcription, documentation, and prompt follow-up for the physician's signature..." Based on record review and interview, the facility failed to			

transcribe a physician's order for 1 of 7 residents reviewed for pharmacy services. (Resident G)

Findings include:

The clinical record for Resident G was reviewed on 02/03/2026 at 10:16 A.M. The resident's diagnosis included, but was not limited to, pain.

A Narcotic Count Book indicated the resident had a narcotic sheet for Oxycodone-APAP (acetaminophen) 5-325 milligrams (mg). The medication was signed out by staff on the following dates and times:

-On 08/06/2025 at 8:00 P.M.,

-On 08/07/2025 at 7:20 A.M.,

-On 08/08/2025 at 7:50 A.M., and

-On 09/16/2025 at 7:00 P.M.

The August 2025 MAR (Medication Administration Record) lacked a physician's order for the resident to have been administered oxycodone (pain) medication.

The September 2025 MAR indicated the resident had a physician's order, with a start date of 08/06/2025, for the resident's Oxycodone-APAP 5-325 mg, 1 tablet every 6 hours

	as needed. During an interview, on 02/03/2026 at 9:50 A.M., the Director of Nursing (DON) indicated the resident's oxycodone medication was not transcribed to the MAR in August and should have been. The current facility policy titled, "Telephone Orders" was revised on 09/17/2025 and was provided by the Administrator on 02/03/2026 at 1:47 P.M. The policy indicated, "...Receiving a Telephone Order...The nurse must:...Document the order immediately...Include the specific medication, treatment, dosage, frequency, route, and reason if applicable...Documentation Requirements...All orders must be documented in the resident's clinical record or designated telephone order form...Staff Responsibilities...Licensed Nurse: Ensure accurate transcription, documentation, and prompt follow-up for the physician's signature..."			
R 0298	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(c)(2) (2) A consultant pharmacist shall be employed, or under contract, and shall:	R 0298	With the change to electronic MAR, the pharmacy places all new orders in the system. These orders must be verified by the nurse. The DHW or designee will monitor for orders needing verified daily. An audit tool is being used to help track	

	(A) be responsible for the duties as specified in 856 IAC 1-7; (B) review the drug handling and storage practices in the facility; (C) provide consultation on methods and procedures of ordering, storing, administering, and disposing of drugs as well as medication record keeping; (D) report, in writing, to the administrator or his or her designee any irregularities in dispensing or administration of drugs; and (E) review the drug regimen of each resident receiving these services at least once every sixty (60) days. Based on observation, interview, and record review, the facility failed to store and handle residents' controlled substance medications appropriatly for 2 of 2 medication carts reviewed for pharmacy services. (100 Hall and 200 Hall medication Carts) Findings include: 1. During an observation, on 02/02/2026 at 12:20 P.M., Qualified Medication Aide (QMA) 3 was counting the residents' controlled substances in the 200-Hall medication cart. The following was observed: -A blister pack for Resident F that contained Xanax (an		all monitoring and began the day we received the citation. Nursing staff is being educated on physicians orders and will be completed by all on schedule by 02/20/26 prior to their next scheduled shift. Attached is the audit tool. This POC will be the same as the 0064 as well. Staff will be educated on not taping meds back in.	

anxiety medication) 0.25 milligrams (mg) tablets. There were 11 tablets in the pack with the 11th tablet taped back into the package,

- A blister pack for Resident F that contained Lunesta (a sleep medication) 1 mg tablets, there were 11 tablets in the pack with the 11th tablet taped back into the package.

2. During an observation on 02/02/2026 at 12:47 P.M., QMA 3 was counting the residents' controlled substances in the 100-Hall medication cart. The following was observed:

- A blister pack for Resident G that contained Oxycodone-APAP (Acetaminophen) 5-325 mg, there were 12 tablets in the pack with the 11th and 12th tablets taped back into the pack.

-There were two blister packs for Resident C that contained Klonopin (an anxiety medication) 0.5 mg. One package contained 25 tablets and one package contained 60 tablets. The resident's controlled substance medication sheets indicated there should have been 25 tablets and 59 tablets in the packs.

During an interview, on 02/02/2026 at 12:47 P.M., QMA 3 indicated nursing staff were to

count the medication carts when they came on shift and before they left. Sometimes there wasn't a second person to count the cart with. The QMA indicated she had not counted the controled medications in the cart that morning.

During an interview, on 02/02/2026 at 1:04 P.M., the Director of Nursing (DON) indicated that staff should be counting controlled substances when starting and stopping their shift. Somedays there were not two staff members available to count medications together. When there wasn't a second person to count the medications then they should count the cart themselves and if there were any discrepancies then they should alert her. She had not had any calls from staff that the narcotics counts had been off.

The current facility policy titled, "Misappropriation of Narcotics & Narcotic Count" was provided by the Administrator on 02/03/2026 at 10:56 A.M. The policy indicated, "...Narcotic Count: A documented inventory of controlled substances verifying accurate quantities at each shift change and is as required...A narcotic count shall be conducted at every shift change...The oncoming and off-going staff must: Physically count each narcotic...Verify

against the narcotic log and Medication Administration Record (MAR)...Counts must also be completed...when a cart is accessed by a different staff member...All counts must be documented immediately..."

The citation relates to Intake 465904.

Based on observation, interview, and record review, the facility failed to store and handle residents' controlled substance medications appropriatly for 2 of 2 medication carts reviewed for pharmacy services. (100 Hall and 200 Hall medication Carts)

Findings include:

1. During an observation, on 02/02/2026 at 12:20 P.M., Qualified Medication Aide (QMA) 3 was counting the residents' controlled substances in the 200-Hall medication cart. The following was observed:

-A blister pack for Resident F that contained Xanax (an anxiety medication) 0.25 milligrams (mg) tablets. There were 11 tablets in the pack with the 11th tablet taped back into the package,

- A blister pack for Resident F that contained Lunesta (a sleep medication) 1 mg tablets, there were 11 tablets in the pack with the 11th tablet taped back into

the package.

2. During an observation on 02/02/2026 at 12:47 P.M., QMA 3 was counting the residents' controlled substances in the 100-Hall medication cart. The following was observed:

- A blister pack for Resident G that contained Oxycodone-APAP (Acetaminophen) 5-325 mg, there were 12 tablets in the pack with the 11th and 12th tablets taped back into the pack.

-There were two blister packs for Resident C that contained Klonopin (an anxiety medication) 0.5 mg. One package contained 25 tablets and one package contained 60 tablets. The resident's controlled substance medication sheets indicated there should have been 25 tablets and 59 tablets in the packs.

During an interview, on 02/02/2026 at 12:47 P.M., QMA 3 indicated nursing staff were to count the medication carts when they came on shift and before they left. Sometimes there wasn't a second person to count the cart with. The QMA indicated she had not counted the controled medications in the cart that morning.

During an interview, on 02/02/2026 at 1:04 P.M., the

	Director of Nursing (DON) indicated that staff should be counting controlled substances when starting and stopping their shift. Somedays there were not two staff members available to count medications together. When there wasn't a second person to count the medications then they should count the cart themselves and if there were any discrepancies then they should alert her. She had not had any calls from staff that the narcotics counts had been off. The current facility policy titled, "Misappropriation of Narcotics & Narcotic Count" was provided by the Administrator on 02/03/2026 at 10:56 A.M. The policy indicated, "...Narcotic Count: A documented inventory of controlled substances verifying accurate quantities at each shift change and is as required...A narcotic count shall be conducted at every shift change...The oncoming and off-going staff must: Physically count each narcotic...Verify against the narcotic log and Medication Administration Record (MAR)...Counts must also be completed...when a cart is accessed by a different staff member...All counts must be documented immediately..." The citation relates to Intake 465904.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREJamie Smith	TITLEAdministrator	(X6) DATE02/13/2026