STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY DEVELOPMENT CORPORATION OF MISHAWAKA, IN	500 LINCOLNWAY EAST, MISHAWAKA, , 46544

(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 Complaint IN00461959. Complaint IN00461959 - State deficiencies related to the allegations are cited at R0052, R0243 and R0349. Survey date: July 7, 2025 Facility number: 012688 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality Review completed on 7/17/2025	R 0000	N/A	
R 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse;	R 0052	1. Corrective Action Taken for Resident B On April 11th, 2025, Resident B's current pain management regimen was	08/07/2025

	(2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on record review and interview, the facility failed to administer physician ordered narcotic medication to a resident for eight administrations. This deficient practice resulted in the resident experiencing physical withdraw symptoms of nausea, vomiting, diarrhea and excessive sweating and mental anguish for 1 of 4 residents for abuse. (Resident B) Finding includes: A record review for Resident B was completed on 7/7/2025 at 10:02 A.M. Diagnoses included, but were not limited to: anxiety disorder, unspecified mood disorder and long-term use of opiate analgesic. A Service Plan, dated 9/6/2024, indicated Resident B required staff to administer her medications. A Physician's Order, dated 1/29/2025, indicated hydrocodone-acetaminophen 1-325 milligrams one tablet by mouth three times a day. The		reviewed and reinstated based on clinical necessity and in accordance with the physician's order. Counseling and emotional support services were offered to Resident B. A written apology was provided, and the grievance was resolved in writing. 2. Measures to Prevent Reoccurrence Policy & Procedure Implementation A new Medication Safety and Nursing Staff Protection in Absence of Timely Physician Response Policy has been developed and implemented on July 10th, 2025. This policy includes:	

	hydrocode-acetaminophen was scheduled to be given at 7:00 A.M., 2:00 P.M. and 7:00 P.M. An Individual Resident Control Medication Record Sheet, dated 3/23/2025, indicated Resident B left the facility for one week with 81 tablets of hydrocodone-acetaminophen and returned to the facility on 4/8/2025 with 43.5 tablets. A Nursing Progress Note, on 4/8/2025 (Tuesday) at 4:45 P.M., indicated Resident B had returned to the facility [from her vacation] and the hydrocodone-acetaminophen narcotic count was incorrect. The note indicated Resident B left with 81 tablets of the hydrocodone-acetaminophen, returned to the facility with 43 tablets and should have returned with 50 tablets. Resident B had indicated she was aware the narcotic count was incorrect, and she had taken more tablets due to excessive walking through the airport. The note indicated Resident B's hydrocodone-acetaminophen should be held until Friday [4/11/2025] per the Director of Nursing's direction. A Nursing Progress Note, on 4/10/2025 at 12:30 P.M., indicated LPN 2 had spoken with the physician's office and the medical assistant had		When concerns about medication administration occur— such as: - changes in resident conditions, - possible side effects, - Resident returning from LOA with fewer pills than expected based on prescribed dosing schedule, raising concern for possible or improperly administered doses - interactions - questionable medication orders and the resident’s physician is unavailable or unresponsive, the following steps shall be taken to protect resident safety and nursing staff from liability: 1.document all concerns or changes in condition related to the	

	instructed the facility to hold the hydrocodone-acetaminophen until the narcotic count was corrected. The physician's office would not send a new prescription for the hydrocodone-acetaminophen until the refill for the medication was due. In addition, the note indicated the physician indicated he would not refill the prescription for the hydrocodone-acetaminophen after the next refill due to improper self-administration of Resident B's hydrocodone-acetaminophen medication. In addition, Resident B would need to find another pain management physician. However, a physician's order was never written to hold the hydrocodone-acetaminophen. The Medication Administration Record (MAR), dated April 2025, indicated the hydrocodone-acetaminophen was held on 4/8/2025 at 7:00 P.M. through 4/11/2025 at 7:00 A.M. Eight consecutive doses of the hydrocodone-acetaminophen were held from Resident B. On 6/19/2025, Resident B submitted a grievance form to the facility administrator after encouragement from another resident. The grievance indicated, "Medication being withheld w/o (without) Dr's		medication 2.Immediate attempts to contact the prescribing physician shall be made and logged, including date, time, and method 3.The DON may place the medication on hold temporarily if continuing it may pose a risk, using nursing judgment. All decisions must be: a.Documented b.Communicated to the resident and/or representative c.Reported to the physician once contact is re-established 4.No response is received within a clinically appropriate timeframe (2–4 hours) urgent matters, like pain medication or other critical medication which could be detrimental to residents' health), resident will be sent out to	

	(doctor's) authorization causing patient to go into severe withdrawals for 4 days. Count on narcotics was not verified when returned to facility. Patient suffered violent withdraw symptoms w/o care or compassion ...." The grievance form went on to define elder abuse and neglect definitions that Resident B had researched on an Indiana governmental website. A Physician Call Log was obtained from Resident B's physician office. The call log indicated QMA 7 had called the physician's office, on 4/9/2025 at 2:17 P.M. and at 3:11 P.M., and indicated Resident B had taken more hydrocodone-acetaminophen than prescribed while on vacation, needed clarification on the hydrocodone-acetaminophen and Resident B no longer had any of her hydrocodone-acetaminophen. The response from the physician, on 4/9/2025 at 3:00 P.M., was he would refill the prescription one more time, he would not prescribe more pain medications going forward and Resident B needed to find another physician to prescribe her pain medications. There were no instructions to hold Resident B's pain medication. A Physician Call Log, on		emergency room for physician evaluation. Training All licensed nurses, QMAs, and medication aides received mandatory retraining on: Medication administration according to physician orders. Communication protocols with physicians. Documentation standards. Pain and withdrawal symptom recognition. Abuse and neglect prevention responsibilities. The Director of Nursing and all supervisory clinical staff completed targeted leadership training emphasizing scope of practice, delegation, and clinical decision-making limitations.	

	4/10/2025 at 10:05 A.M., indicated LPN 2 had called the physician's office and stated Resident B had a few pills left, but would need refilled before 4/21/2025 and would give the message to Resident B to find a new pain physician. However, the call log had no documentation the physician had given orders to withhold the hydrocodone-acetaminophen. During an interview, on 7/7/2025 at 10:47 A.M., Resident B indicated her hydrocodone-acetaminophen had been withheld for four days and she had had violent withdrawal symptoms including nausea, vomiting, diarrhea and sweating and suffered mentally from the withdraw symptoms. She indicated she had been on narcotic medication for ten years. Resident B indicated she had taken an extra hydrocodone-acetaminophen while on vacation because the trip was harder on her than she had anticipated. She indicated the Director of Nursing did not have the authorization to withhold her medication without a doctor's approval. During an interview, on 7/7/2025 at 1:33 P.M., LPN 2 indicated she had counted the hydrocodone-acetaminophen upon Resident B's return to the facility and the count was short. LPN 2 informed the Director of		3. Monitoring and Quality Assurance Weekly Audits: The facility's DON will conduct weekly audits of MARs and narcotic counts for all residents on scheduled narcotic medications to ensure: No medications are held without a valid, documented physician order. Proper documentation of medication administration and pain assessments. Grievance Log Reviews: All resident grievances related to medications, pain, or care concerns will be reviewed monthly by the Administrator. Random Interviews: Monthly random resident interviews will be conducted by DON and	

	Nursing about the missing hydrocodone-acetaminophen and the Director of Nursing gave the directive to hold the hydrocodone-acetaminophen until the physician could be contacted. LPN 2 indicated she had called the physician's office for a refill and the physician's office indicated they would not refill the hydrocodone-acetaminophen or provide refills in the future, Resident B needed to find a new pain management physician and to hold the hydrocodone-acetaminophen until the narcotic count was corrected. LPN 2 indicated there was not a written physician's order to hold the hydrocodone-acetaminophen and the physician was not aware of the Director of Nursing's directive to hold the medication. LPN 2 indicated there were no pain assessments completed on Resident B during the period the hydrocodone-acetaminophen had been held. During an interview, on 7/7/2025 at 1:48 P.M., the Director of Nursing indicated Resident B had returned from her vacation, and when staff had counted her hydrocodone-acetominophen tablets, some of the medication was missing. She indicated the nursing staff had asked if they should administer the hydrocodone-acetaminophen as		Administrator to assess resident satisfaction with pain management and medication administration for six months. 4. Responsible Parties Administrator – ensures grievance response, monitors implementation of policy changes Director of Nursing – responsible for staff education, narcotic oversight, and clinical compliance 5. Completion Date All corrective actions will be fully implemented by: August 7th, 2025	

	ordered and she told the nursing staff to contact the physician for a new prescription. The Director of Nursing indicated she felt the hydrocodone-acetaminophen should have been held due to a history of alcoholism and was not certain that Resident B had not held onto the missing medication.The Director of Nursing indicated she had observed Resident B coming in and out of the building and Resident B asked about her pain medication, but the Director of Nursing indicated she had not administer the pain medication due to not knowing if the medication would harm Resident B. The Director of Nursing indicated a formal assessment had not been completed for Resident B for withdraw symptoms or pain. During an interview, on 7/8/2025 at 9:40 A.M., with Resident B's physician, he indicated he had not given an order to hold the hydrocodone-acetaminophen, and his medical assistant had not given an order to the nursing staff either. He indicated he planned to continue to prescribe Resident B's pain medication as Resident B had talked to him multiple times about why she taken more than the prescribed dosage while on vacation. A policy was requested, on			

7/7/2025 at 1:32 P.M., for narcotic medication administration. At 2:31 P.M., the Director of Nursing indicated a policy was not available.

This citation relates to complaint IN00461959.

Based on record review and interview, the facility failed to administer physician ordered narcotic medication to a resident for eight administrations. This deficient practice resulted in the resident experiencing physical withdraw symptoms of nausea, vomiting, diarrhea and excessive sweating and mental anguish for 1 of 4 residents for abuse. (Resident B)

Finding includes:

A record review for Resident B was completed on 7/7/2025 at 10:02 A.M. Diagnoses included, but were not limited to: anxiety disorder, unspecified mood disorder and long-term use of opiate analgesic.

A Service Plan, dated 9/6/2024, indicated Resident B required staff to administer her medications.

A Physician's Order, dated 1/29/2025, indicated hydrocodone-acetaminophen 1-325 milligrams one tablet by mouth three times a day. The hydrocode-acetaminophen was scheduled to be given at 7:00

	A.M., 2:00 P.M. and 7:00 P.M. An Individual Resident Control Medication Record Sheet, dated 3/23/2025, indicated Resident B left the facility for one week with 81 tablets of hydrocodone-acetaminophen and returned to the facility on 4/8/2025 with 43.5 tablets. A Nursing Progress Note, on 4/8/2025 (Tuesday) at 4:45 P.M., indicated Resident B had returned to the facility [from her vacation] and the hydrocodone-acetaminophen narcotic count was incorrect. The note indicated Resident B left with 81 tablets of the hydrocodone-acetaminophen, returned to the facility with 43 tablets and should have returned with 50 tablets. Resident B had indicated she was aware the narcotic count was incorrect, and she had taken more tablets due to excessive walking through the airport. The note indicated Resident B's hydrocodone-acetaminophen should be held until Friday [4/11/2025] per the Director of Nursing's direction. A Nursing Progress Note, on 4/10/2025 at 12:30 P.M., indicated LPN 2 had spoken with the physician's office and the medical assistant had instructed the facility to hold the hydrocodone-acetaminophen			

	until the narcotic count was corrected. The physician's office would not send a new prescription for the hydrocodone-acetaminophen until the refill for the medication was due. In addition, the note indicated the physician indicated he would not refill the prescription for the hydrocodone-acetaminophen after the next refill due to improper self-administration of Resident B's hydrocodone-acetaminophen medication. In addition, Resident B would need to find another pain management physician. However, a physician's order was never written to hold the hydrocodone-acetaminophen. The Medication Administration Record (MAR), dated April 2025, indicated the hydrocodone-acetaminophen was held on 4/8/2025 at 7:00 P.M. through 4/11/2025 at 7:00 A.M. Eight consecutive doses of the hydrocodone-acetaminophen were held from Resident B. On 6/19/2025, Resident B submitted a grievance form to the facility administrator after encouragement from another resident. The grievance indicated, "Medication being withheld w/o (without) Dr's (doctor's) authorization causing patient to go into severe			

	withdrawals for 4 days. Count on narcotics was not verified when returned to facility. Patient suffered violent withdraw symptoms w/o care or compassion ...." The grievance form went on to define elder abuse and neglect definitions that Resident B had researched on an Indiana governmental website. A Physician Call Log was obtained from Resident B's physician office. The call log indicated QMA 7 had called the physician's office, on 4/9/2025 at 2:17 P.M. and at 3:11 P.M., and indicated Resident B had taken more hydrocodone-acetaminophen than prescribed while on vacation, needed clarification on the hydrocodone-acetaminophen and Resident B no longer had any of her hydrocodone-acetaminophen. The response from the physician, on 4/9/2025 at 3:00 P.M., was he would refill the prescription one more time, he would not prescribe more pain medications going forward and Resident B needed to find another physician to prescribe her pain medications. There were no instructions to hold Resident B's pain medication. A Physician Call Log, on 4/10/2025 at 10:05 A.M., indicated LPN 2 had called the			

	physician's office and stated Resident B had a few pills left, but would need refilled before 4/21/2025 and would give the message to Resident B to find a new pain physician. However, the call log had no documentation the physician had given orders to withhold the hydrocodone-acetaminophen. During an interview, on 7/7/2025 at 10:47 A.M., Resident B indicated her hydrocodone-acetaminophen had been withheld for four days and she had had violent withdrawal symptoms including nausea, vomiting, diarrhea and sweating and suffered mentally from the withdraw symptoms. She indicated she had been on narcotic medication for ten years. Resident B indicated she had taken an extra hydrocodone-acetaminophen while on vacation because the trip was harder on her than she had anticipated. She indicated the Director of Nursing did not have the authorization to withhold her medication without a doctor's approval. During an interview, on 7/7/2025 at 1:33 P.M., LPN 2 indicated she had counted the hydrocodone-acetaminophen upon Resident B's return to the facility and the count was short. LPN 2 informed the Director of Nursing about the missing hydrocodone-acetaminophen			

	and the Director of Nursing gave the directive to hold the hydrocodone-acetaminophen until the physician could be contacted. LPN 2 indicated she had called the physician's office for a refill and the physician's office indicated they would not refill the hydrocodone-acetaminophen or provide refills in the future, Resident B needed to find a new pain management physician and to hold the hydrocodone-acetaminophen until the narcotic count was corrected. LPN 2 indicated there was not a written physician's order to hold the hydrocodone-acetaminophen and the physician was not aware of the Director of Nursing's directive to hold the medication. LPN 2 indicated there were no pain assessments completed on Resident B during the period the hydrocodone-acetaminophen had been held. During an interview, on 7/7/2025 at 1:48 P.M., the Director of Nursing indicated Resident B had returned from her vacation, and when staff had counted her hydrocodone-acetominophen tablets, some of the medication was missing. She indicated the nursing staff had asked if they should administer the hydrocodone-acetaminophen as ordered and she told the nursing staff to contact the			

	physician for a new prescription. The Director of Nursing indicated she felt the hydrocodone-acetaminophen should have been held due to a history of alcoholism and was not certain that Resident B had not held onto the missing medication.The Director of Nursing indicated she had observed Resident B coming in and out of the building and Resident B asked about her pain medication, but the Director of Nursing indicated she had not administer the pain medication due to not knowing if the medication would harm Resident B. The Director of Nursing indicated a formal assessment had not been completed for Resident B for withdraw symptoms or pain. During an interview, on 7/8/2025 at 9:40 A.M., with Resident B's physician, he indicated he had not given an order to hold the hydrocodone-acetaminophen, and his medical assistant had not given an order to the nursing staff either. He indicated he planned to continue to prescribe Resident B's pain medication as Resident B had talked to him multiple times about why she taken more than the prescribed dosage while on vacation. A policy was requested, on 7/7/2025 at 1:32 P.M., for narcotic medication			

	administration. At 2:31 P.M., the Director of Nursing indicated a policy was not available. This citation relates to complaint IN00461959.			
R 0243	Health Services - Deficiency 410 IAC 16.2-5-4(e)(3) (3) The individual administering the medication shall document the administration in the individual ' s medication and treatment records that indicate the: (A) time; (B) name of medication or treatment; (C) dosage (if applicable); and (D) name or initials of the person administering the drug or treatment. Based on record review and interview the facility failed to ensure medications administered were documented appropriately in the medical record for 1 of 4 residents reviewed for medication administration. (Resident D) Finding includes: The record for Resident D was completed on 7/7/2025 at 10:46 A.M. Diagnoses included, but were not limited to diabetes, schizoaffective disorder,	R 0243	1. Corrective Action for Affected Resident: Resident D's MAR and narcotic count records for May and June 2025 have been reviewed. A retrospective audit was conducted to reconcile the discrepancies. No adverse effects to Resident D were noted. The physician and responsible party have been notified of the documentation error. 2. Identification of Other Residents Affected:	08/07/2025

	anxiety, atrial fibrillation, and congestive heart failure. Resident D's current Physician Orders included, but were not limited to, Oxycodone/Acetaminophen (narcotic) 7.5/325 mg (milligram) 1 tablet every 8 hours as needed for pain. The Medication Administration Record (MAR), dated May 2025, indicated Resident D received the Oxycodone medication only 1 time per day on the following dates: - 5/3 through 5/5, 5/14, 5/15, 5/18, 5/24 and on 5/25/2025. However, the Individual Resident Control Medication Record Sheet (Narcotic Count Sheet), dated 5/1 to 5/30/2025, for the Oxycodone medication indicated the resident had received the Oxycodone 2 times a day on the following dates: 5/3 through 5/5, 5/14, 5/15, 5/18, 5/24 and on 5/25/2025.- The Medication Administration Record (MAR) dated June 2025 indicated Resident D received the Oxycodone medication only 1 time per day on the following dates: 6/7, 6/8, 6/12, 6/14, 6/16, 6/17, 6/22, 6/23 and on 6/27/2025. However, the Individual		An audit of all current residents receiving PRN narcotic medications has been completed. Any discrepancies found were reviewed by nursing administration and corrected. No additional residents were found to have similar documentation errors. 3. Systemic Changes to Prevent Recurrence: All licensed nurses and QMAs received re-education on: Proper documentation of PRN medications on both the MAR and narcotic count sheet. Timing of documentation – immediately after medication administration.	

	Resident Control Medication Record Sheet, dated 6/1 to 6/28/2025, for the Oxycodone medication indicated the resident had received the Oxycodone 2 times per day on the following dates: 6/7, 6/8, 6/12, 6/14, 6/16, 6/17, 6/22, 6/23 and on 6/27/2025. During an interview, on 7/7/2025 at 1:42 P.M., the Director of Nursing indicated staff should have documented the pain medications on the MAR and on the Narcotic count sheets. She confirmed the narcotic count sheets did not match what was documented on the MAR. The Director of Nursing indicated there was no way to tell if the resident's medication had been given and the discrepency could support a potential misappropriation of property. During an interview, on 7/7/2025 at 2:38 P.M., QMA 3 indicated after giving the as needed pain (PRN) pain medication, she should have documented the medication administration on both the MAR and on the narcotic count sheet. During an interview, on 7/7/2025 at 2:45 P.M., QMA 6 indicated after a PRN (as needed) pain medication was administered, it should be documented on the narcotic count sheet and on the MAR in the electronic chart. She		Facility's Medication Administration Policy (dated 6/19/2025). 4. Monitoring and Quality Assurance: The Director of Nursing (DON) or designee will perform weekly random audits of PRN narcotic documentation for 30 days, then monthly for 6 months. Any discrepancies will be addressed immediately with the responsible staff. 5. Completion Date: Date of Compliance: August 7th, 2025	

indicated narcotics were counted before and after each shift.

On 7/7/2025 at 1:59 P.M., the Director of Nursing provided the policy titled, "Medication Administration Policy Standards", dated 6/19/2025, and indicated the policy was the one currently used by the facility. The policy indicated "...5. Documentation. All administered medications must be documented on the Medication Administration Record (MAR) immediately after administration...."

This citation relates to complaint IN00461959.

Based on record review and interview the facility failed to ensure medications administered were documented appropriately in the medical record for 1 of 4 residents reviewed for medication administration. (Resident D)

Finding includes:

The record for Resident D was completed on 7/7/2025 at 10:46 A.M. Diagnoses included, but were not limited to diabetes, schizoaffective disorder, anxiety, atrial fibrillation, and congestive heart failure.

Resident D's current Physician Orders included, but were not limited to,

	Oxycodone/Acetaminophen (narcotic) 7.5/325 mg (milligram) 1 tablet every 8 hours as needed for pain. The Medication Administration Record (MAR), dated May 2025, indicated Resident D received the Oxycodone medication only 1 time per day on the following dates: - 5/3 through 5/5, 5/14, 5/15, 5/18, 5/24 and on 5/25/2025. However, the Individual Resident Control Medication Record Sheet (Narcotic Count Sheet), dated 5/1 to 5/30/2025, for the Oxycodone medication indicated the resident had received the Oxycodone 2 times a day on the following dates: 5/3 through 5/5, 5/14, 5/15, 5/18, 5/24 and on 5/25/2025.- The Medication Administration Record (MAR) dated June 2025 indicated Resident D received the Oxycodone medication only 1 time per day on the following dates: 6/7, 6/8, 6/12, 6/14, 6/16, 6/17, 6/22, 6/23 and on 6/27/2025. However, the Individual Resident Control Medication Record Sheet, dated 6/1 to 6/28/2025, for the Oxycodone medication indicated the resident had received the Oxycodone 2 times per day on			

	the following dates: 6/7, 6/8, 6/12, 6/14, 6/16, 6/17, 6/22, 6/23 and on 6/27/2025. During an interview, on 7/7/2025 at 1:42 P.M., the Director of Nursing indicated staff should have documented the pain medications on the MAR and on the Narcotic count sheets. She confirmed the narcotic count sheets did not match what was documented on the MAR. The Director of Nursing indicated there was no way to tell if the resident's medication had been given and the discrepency could support a potential misappropriation of property. During an interview, on 7/7/2025 at 2:38 P.M., QMA 3 indicated after giving the as needed pain (PRN) pain medication, she should have documented the medication administration on both the MAR and on the narcotic count sheet. During an interview, on 7/7/2025 at 2:45 P.M., QMA 6 indicated after a PRN (as needed) pain medication was administered, it should be documented on the narcotic count sheet and on the MAR in the electronic chart. She indicated narcotics were counted before and after each shift. On 7/7/2025 at 1:59 P.M., the Director of Nursing provided the policy titled, "Medication			

	Administration Policy Standards", dated 6/19/2025, and indicated the policy was the one currently used by the facility. The policy indicated "...5. Documentation. All administered medications must be documented on the Medication Administration Record (MAR) immediately after administration...." This citation relates to complaint IN00461959.			
R 0349	Clinical Records - Noncompliance 410 IAC 16.2-5-8.1(a)(1-4) (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were accurately documented regarding Medication Administration Records and Narcotic medications count sheets for 1 of 1 residents	R 0349	1. Corrective Action for Affected Resident: Clinical records for Resident D were audited and corrected to ensure the MAR and Narcotic Count Sheet are consistent. No signs of harm were noted for Resident D. The physician and legal representative were notified of the documentation error. 2. Identification of Other	08/07/2025

reviewed for medication administration. (Resident D)

Finding includes:

The record for Resident D was completed on 7/7/2025 at 10:46 A.M. Diagnoses included, but were not limited to diabetes, schizoaffective disorder, anxiety, atrial fibrillation, and congestive heart failure.

Resident D's current Physician Orders included but were not limited to Oxycodone/Acetaminophen (narcotic) 7.5/325 mg (milligram) 1 tablet every 8 hours as needed for pain.

The Medication Administration Record (MAR) dated May 2025, indicated Resident D received the Oxycodone medication only 1 time per day on the following dates:

- 5/3 through 5/5, 5/14, 5/15, 5/18, 5/24 and on 5/25/2025.

The Individual Resident Control Medication Record Sheet (Narcotic Count Sheet), dated 5/1 to 5/30/2025, for the Oxycodone medication indicated the resident had received the Oxycodone 2 times per day on the following dates:

5/3 through 5/5, 5/14, 5/15, 5/18, 5/24 and on 5/25/2025.-

The Medication Administration

Residents:

A facility-wide audit of all residents receiving PRN narcotic medications was conducted.

All inconsistencies found were corrected.

No other residents were found to be affected by the same issue.

3. Systemic Changes to Prevent Recurrence:

All licensed nurses and QMAs were re-educated on:

Proper and immediate documentation of all PRN medications on both the MAR and the narcotic count sheet.

Facility’s Medication Administration Policy

Record (MAR), dated June 2025, indicated Resident D received the Oxycodone medication only 1 time per day on the following dates:

6/7, 6/8, 6/12, 6/14, 6/16, 6/17, 6/22, 6/23 and on 6/27/2025.

The Individual Resident Control Medication Record Sheet, dated 6/1 to 6/28/2025, for the Oxycodone medication indicated the resident had received the Oxycodone 2 times per day on the following dates:

6/7, 6/8, 6/12, 6/14, 6/16, 6/17, 6/22, 6/23 and on 6/27/2025.

During an interview, on 7/7/2025 at 1:42 P.M., the Director of Nursing indicated the staff should have documented the pain medications on the MAR and on the Narcotic count sheets. She cofirmed the narcotic count sheets had not matched what was documented on the MAR. The Director of Nursing indicated there was no was to tell if the resident's medication had been given and the discrepency could have indicated a misappropriation of property.

During an interview, on 7/7/2025 at 2:38 P.M., QMA 3 indicated after giving an as needed pain (PRN) medication, she should have documented the medication administration on both the MAR and on the

Standards dated 6/19/2025.

A new documentation protocol was implemented to:

Ensure
PRN entries are verified in both locations (MAR and narcotic sheet).

4. Quality Assurance and Monitoring:

The DON or designee will complete weekly audits of narcotic documentation for 30 days, then monthly for 6 months.

Any discrepancies will be corrected immediately, and staff involved will be re-educated.

5. Completion Date:

Date of Compliance: August 7th, 2025

narcotic count sheet.

During an interview, on 7/7/2025 at 2:45 P.M., QMA 6 indicated after a PRN (as needed) pain medication was administered, it should be documented in the narcotic count sheet and on the MAR in the electronic chart. She indicated narcotics were counted before and after each shift.

On 7/7/2025 at 1:59 P.M., the Director of Nursing provided the policy titled, "Medication Administration Policy Standards", dated 6/19/2025, and indicated the policy was the one currently used by the facility. The policy indicated "...5. Documentation. All administered medications must be documented on the Medication Administration Record (MAR) immediately after administration...."

This citation relates to complaint IN00461959.

Based on record review and interview, the facility failed to ensure clinical records were accurately documented regarding Medication Administration Records and Narcotic medications count sheets for 1 of 1 residents reviewed for medication administration. (Resident D)

Finding includes:

	The record for Resident D was completed on 7/7/2025 at 10:46 A.M. Diagnoses included, but were not limited to diabetes, schizoaffective disorder, anxiety, atrial fibrillation, and congestive heart failure. Resident D's current Physician Orders included but were not limited to Oxycodone/Acetaminophen (narcotic) 7.5/325 mg (milligram) 1 tablet every 8 hours as needed for pain. The Medication Administration Record (MAR) dated May 2025, indicated Resident D received the Oxycodone medication only 1 time per day on the following dates: - 5/3 through 5/5, 5/14, 5/15, 5/18, 5/24 and on 5/25/2025. The Individual Resident Control Medication Record Sheet (Narcotic Count Sheet), dated 5/1 to 5/30/2025, for the Oxycodone medication indicated the resident had received the Oxycodone 2 times per day on the following dates: 5/3 through 5/5, 5/14, 5/15, 5/18, 5/24 and on 5/25/2025.-			

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6/7, 6/8, 6/12, 6/14, 6/16, 6/17, 6/22, 6/23 and on 6/27/2025.

The Individual Resident Control Medication Record Sheet, dated 6/1 to 6/28/2025, for the Oxycodone medication indicated the resident had received the Oxycodone 2 times per day on the following dates:

6/7, 6/8, 6/12, 6/14, 6/16, 6/17, 6/22, 6/23 and on 6/27/2025.

During an interview, on 7/7/2025 at 1:42 P.M., the Director of Nursing indicated the staff should have documented the pain medications on the MAR and on the Narcotic count sheets. She cofirmed the narcotic count sheets had not matched what was documented on the MAR. The Director of Nursing indicated there was no was to tell if the resident's medication had been given and the discrepency could have indicated a misappropriation of property.

During an interview, on 7/7/2025 at 2:38 P.M., QMA 3 indicated after giving an as needed pain (PRN) medication, she should have documented the medication administration on

	both the MAR and on the narcotic count sheet. During an interview, on 7/7/2025 at 2:45 P.M., QMA 6 indicated after a PRN (as needed) pain medication was administered, it should be documented in the narcotic count sheet and on the MAR in the electronic chart. She indicated narcotics were counted before and after each shift. On 7/7/2025 at 1:59 P.M., the Director of Nursing provided the policy titled, "Medication Administration Policy Standards", dated 6/19/2025, and indicated the policy was the one currently used by the facility. The policy indicated "...5. Documentation. All administered medications must be documented on the Medication Administration Record (MAR) immediately after administration...." This citation relates to complaint IN00461959.			

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 SIGNATURE	TITLE	(X6) DATE