STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	07/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LINCOLNSHIRE PLACE - MUNCIE	1600 N MORRISON ROAD, MUNCIE, , 47304

(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 a State Residential Licensure Survey. Survey dates: July 14 and 15, 2025 Facility number: 014463 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed July 16, 2025	R 0000	All POC will be complete by August 31st or before if stated.	
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire	R 0092	Current process was not completed for the first quarter of 2025. The current form and process of how to conduct the fire drill was not changed. The Executive Director has completed a fire drill on 1st and 3rd shifts and will conduct the 2nd shift fire drill by August 31st. I have attached to current form we will be using to document the fire drills and keep in current log book. During the fire drills we reviewed staffs actions	08/31/2025

	alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on interview and record review, the facility failed to ensure fire drills were performed on each shift quarterly to ensure resident safety in the event of a fire. This deficiency had the potential to effect 42 of 42 residents that resided in the facility. Finding includes: The emergency preparedness binder was reviewed on 7/14/25 at 10:10 a.m. . Fire drill documentation was observed for 4/16/25 first shift, 4/17/25 second shift, and 4/18/25 third shift. No record of attendance		that would occur per the fire drill policy. This education will also be given at the next staff meeting on August the 13th with signed attendance sheet. This will ensure that 42of 42 residents will not be effected. Executive Director will complete Quarterly fire drills on each shift and document in fire drill log book. Executive Director and DON will monitor for completion quarterly. Monitoring will be on-going.	

	was present on the fire drill paperwork. The binder lacked any other fire drill documentation. During an interview with the Administrator on 7/15/25 at 11:07 a.m., a request was made for all fire drill information after the last annual survey (11/2024). She was unable to find fire drill documentation for November 2024-March 2025 for first and second shift. During an interview with the Administrator on 7/15/25 at 11:15 a.m., She indicated fire drills should have been conducted on each shift every quarter. A document provided by the Administrator concurrent to the interview indicated a fire drill was performed on 10/24/24 at 5:00 a.m (third shift). During an interview with the Administrator on 7/15/25 at 11:30 a.m., she indicated all fire drill paperwork should have included signature of staff who were in attendance when fire drills were conducted. A document provided by the DON on 7/15/25 at 11:24 a.m. and titled, "Chapter 10: Community Safety", indicated the following: "...Fire drills shall include transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of			

	non-ambulatory resident to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions (times). At least twelve (12) drills shall be held each year ..." Based on interview and record review, the facility failed to ensure fire drills were performed on each shift quarterly to ensure resident safety in the event of a fire. This deficiency had the potential to effect 42 of 42 residents that resided in the facility. Finding includes: The emergency preparedness binder was reviewed on 7/14/25 at 10:10 a.m. . Fire drill documentation was observed for 4/16/25 first shift, 4/17/25 second shift, and 4/18/25 third shift. No record of attendance was present on the fire drill paperwork. The binder lacked any other fire drill documentation. During an interview with the Administrator on 7/15/25 at 11:07 a.m., a request was made for all fire drill information after the last annual survey (11/2024). She was unable to find fire drill documentation for November 2024-March 2025 for			

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R 0117	Personnel - Deficiency	R 0117	We reviewed the staff CPR	08/31/2025

	410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure cardiopulmonary resuscitation (CPR) certified staff were present during all shifts for 3 of 21 shifts reviewed for CPR coverage. This deficiency had the potential to effect 42 of 42 resident who		certifications and staff that were not current for both CPR/first aid had to complete the National CPR foundation training recertification. We are requiring all staff upon hire will provide documentation of CPR/first aid. If new employee is not current and needs certification it will be obtained with-in the orientation period from the National CPR foundation and the facility will provide access to the website for completion. This will ensure that 42/42 residents will not be effected in the future. We created a new log sheet to be keep in our in-service book. I will attach log. The log will be reviewed monthly at the staff meeting by the DON and Executive Director. If the employee is due to expire in the next two coming months a memo will be given to the employee to remind them of the expiration date and they will not be allowed to work until this is complete. I will attach new memo sheet. This monitoring will be on-going.	

	resided in the facility. Finding includes: A current working schedule provided by the DON on 7/14/25 at 2:47 p.m. indicated no CPR certified staff were present in the building on 7/8/25 third shift and 7/10/25 second and third shift. During an interview with the Administrator on 7/15/25 at 1:30 p.m., she indicated CPR and first aid certified staff should have been present in the facility twenty four hours a day. During an interview with the Administrator on 7/15/25 at 1:35 p.m., she was unable to locate a policy regarding CPR certified staff and followed state regulations. No further information was provided prior to exit. Based on interview and record review, the facility failed to ensure cardiopulmonary resuscitation (CPR) certified staff were present during all shifts for 3 of 21 shifts reviewed for CPR coverage. This deficiency had the potential to effect 42 of 42 resident who resided in the facility. Finding includes: A current working schedule provided by the DON on 7/14/25			

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R 0118	Personnel - Deficiency 410 IAC 16.2-5-1.4(c) (c) Any unlicensed employee providing more than limited assistance with the activities of daily living must be either a certified nurse aide or a home health aide. Existing facilities that are not licensed on the date of adoption of this rule and that seek licensure within one (1) year of adoption of this rule have two (2) months in which to ensure that all employees in this category are either a certified nurse aide or a home health aide. Based on interview and record	R 0118	Immediate action was taken and expired QMA sent in required documentation of completed hours and her license was renewed that day. New process has been put into place started on July 18th. We have license expiration log that will be kept in the in-service book and reviewed at monthly staff meeting by the DON and Executive Director. I will attach form and memo. Any staff with a license to expire with-in the next two months will receive a memo of the expire date and they will not be able to work until license is renewed. This will be on-going each month.	07/15/2025

	review, the facility allowed a Qualified Medication Aid (QMA) to provide care with an expired license for 1 of 5 employees reviewed for active licensure. Finding includes: During an interview with the Administrator on 7/14/25 at 2:46 p.m., she indicated QMA 4's certification expired on 6/16/25 and she had been working since that time. A current working schedule, provided by the DON on 7/14/25 at 2:47 p.m. indicated QMA 4 worked the following shifts: 6/17/25 6/18/25 6/22/25 6/23/25 6/26/25 6/30/25 7/2/25 7/4/25 7/7/25 7/10/25 7/12/25 7/13/25 During an interview with the			

	Administrator on 7/15/25 at 10:26 a.m., she indicated QMA 4 worked in the QMA role during the aforementioned shifts. The administrator indicated there was miscommunication between her and QMA 4 regarding certification renewal. She indicated QMA 4 thought the facility would submit her certification paperwork and the facility thought QMA had already submitted it. During an interview with QMA 4 on 7/15/25 at 11:37 a.m., she indicated her certification expired on 6/16/25 and she continued working as a QMA passing medication from 6/16/25 to 7/14/25 when her certification was renewed. QMA indicated there was miscommunication between her and the facility about renewing her certification, noting she knew her certification was about to expire. She renewed her Certified Nurse's Aid (CNA) license and completed the necessary paperwork to renew her QMA, but required in-service hours had to be entered by a nurse, whom she notified. She did not check back and assumed the facility had submitted her hours. During an interview with the Administrator on 7/15/25 at 12:34 p.m., she indicated the facility did not have a policy regarding qualified personnel or			

ensuring staff maintained current licensure and certificates.

Based on interview and record review, the facility allowed a Qualified Medication Aid (QMA) to provide care with an expired license for 1 of 5 employees reviewed for active licensure.

Finding includes:

During an interview with the Administrator on 7/14/25 at 2:46 p.m., she indicated QMA 4's certification expired on 6/16/25 and she had been working since that time.

A current working schedule, provided by the DON on 7/14/25 at 2:47 p.m. indicated QMA 4 worked the following shifts:

6/17/25

6/18/25

6/22/25

6/23/25

6/26/25

6/30/25

7/2/25

7/4/25

7/7/25

7/10/25

	7/12/25 7/13/25 During an interview with the Administrator on 7/15/25 at 10:26 a.m., she indicated QMA 4 worked in the QMA role during the aforementioned shifts. The administrator indicated there was miscommunication between her and QMA 4 regarding certification renewal. She indicated QMA 4 thought the facility would submit her certification paperwork and the facility thought QMA had already submitted it. During an interview with QMA 4 on 7/15/25 at 11:37 a.m., she indicated her certification expired on 6/16/25 and she continued working as a QMA passing medication from 6/16/25 to 7/14/25 when her certification was renewed. QMA indicated there was miscommunication between her and the facility about renewing her certification, noting she knew her certification was about to expire. She renewed her Certified Nurse's Aid (CNA) license and completed the necessary paperwork to renew her QMA, but required in-service hours had to be entered by a nurse, whom she notified. She did not check back and assumed the facility had submitted her hours.			

	During an interview with the Administrator on 7/15/25 at 12:34 p.m., she indicated the facility did not have a policy regarding qualified personnel or ensuring staff maintained current licensure and certificates.			
R 0296	Pharmaceutical Services - Noncompliance 410 IAC 16.2-5-6(b) (b) The facility shall maintain clear 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 ensure staff competency regarding shift to shift controlled substance reconciliation for 2 of 2 medication carts reviewed for medication administration and storage. (100 Unit and 200 Unit medication carts) This deficiency had the potential to affect 20 of 20 residents who received controlled medications from the 100 Unit and 200 Unit medication carts. Findings include: 1. During a medication storage observation of the 200 Unit medication cart, accompanied by QMA 5, on 7/14/25 at 11:44 a.m., the "Controlled	R 0296	New controlled substance sheet was created with instructions for use and immediate education of staff was completed. DON will monitor the controlled substance log sheet on each Friday for signature. The attached instruction sheet explains to staff what to do with the discrepancy if one occurs and who to call. This will be an on-going practice.	07/31/2025

	Substances Shift Change Log" was reviewed from 6/14/25 to 7/14/25. The following dates and times lacked shift to shift reconciliations of controlled medications: June and July 2025- 6/14/25: 7:00 a.m. and 7:00 p.m. 6/15/25: 7:00 a.m. and 7:00 p.m. 6/16/25: 7:00 p.m. 6/17/25: 7:00 p.m. 6/18/25: 7:00 a.m. and 7:00 p.m. 6/19/25: 7:00 a.m. and 7:00 p.m. 6/20/25: 7:00 a.m. and 7:00 p.m. 6/21/25: 7:00 a.m. and 7:00 p.m. 6/22/25: 7:00 p.m. 6/23/25: 7:00 p.m. 6/24/25: 7:00 p.m. 6/25/25: 7:00 a.m. and 7:00 p.m. 6/27/25: 7:00 a.m. and 7:00 p.m.			

	6/28/25: 7:00 a.m. and 7:00 p.m. 6/29/25: 7:00 a.m. and 7:00 p.m. 6/30/25: 7:00 a.m. and 7:00 p.m. 7/1/25: 7:00 a.m. and 7:00 p.m. 7/3/25: 7:00 a.m. and 7:00 p.m. 7/4/25: 7:00 p.m. 7/5/25: 7:00 a.m. and 7:00 p.m. 7/6/25: 7:00 a.m. and 7:00 p.m. 7/8/25: 7:00 a.m. and 7:00 p.m. 7/9/25: 7:00 a.m. and 7:00 p.m. 7/11/25: 7:00 a.m. and 7:00 p.m. 7/12/25: 7:00 a.m. and 7:00 p.m. 7/13/25: 7:00 a.m. and 7:00 p.m. 7/14/25: 7:00 a.m. None of the dates from 6/14/25 to 7/14/25 contained two staff member signatures during the narcotic reconciliation at the beginning and ending of the shifts. During an interview on 7/14/25 at 11:48 a.m., QMA 5 indicated he did not count the controlled substances with an other staff			

	member. He counted the controlled substances by himself on his cart each shift and reported any discrepancies to the DON. The "Controlled Substances Shift Change Log" was blank for 7/14/25. 2. During a medication storage observation of the 100 Unit medication cart, accompanied by QMA 3, on 7/14/25 at 12:12 p.m., the "Controlled Substances Shift Change Log" was reviewed from 6/14/25 to 7/14/25. The following dates and times lacked shift to shift reconciliations of controlled medications: June and July 2025- 6/16/25: 7:00 a.m. and 7:00 p.m. 6/18/25: 7:00 a.m. 6/19/25: 7:00 a.m. and 7:00 p.m. 6/20/25: 7:00 a.m. and 7:00 p.m. 6/21/25: 7:00 p.m. 6/22/25: 7:00 a.m. and 7:00 p.m. 6/23/25: 7:00 a.m. and 7:00 p.m. 6/24/25: 7:00 a.m. and 7:00 p.m.			

	6/25/25: 7:00 a.m. and 7:00 p.m. 6/27/25: 7:00 a.m. and 7:00 p.m. 6/28/25: 7:00 a.m. and 7:00 p.m. 6/29/25: 7:00 a.m. and 7:00 p.m. 6/30/25: 7:00 a.m. 7/1/25: 7:00 a.m. and 7:00 p.m. 7/2/25: 7:00 a.m. 7/3/25: 7:00 a.m. and 7:00 p.m. 7/4/25: 7:00 a.m. 7/5/25: 7:00 a.m. and 7:00 p.m. 7/6/25: 7:00 a.m. and 7:00 p.m. 7/7/25: 7:00 a.m. and 7:00 p.m. 7/8/25: 7:00 a.m. and 7:00 p.m. 7/9/25: 7:00 a.m. and 7:00 p.m. 7/10/25: 7:00 a.m. and 7:00 p.m. 7/11/25: 7:00 a.m. and 7:00 p.m. 7/12/25: 7:00 a.m. 7/13/25: 7:00 a.m. 7/14/25: 7:00 a.m. None of the dates from 6/14/25 to 7/14/25 contained two staff			

	member signatures during the narcotic reconciliation at the beginning and ending of the shifts. During an interview on 7/14/25 at 12:12 p.m., QMA 3 indicated she did the shift to shift narcotic count by herself when she took over the medication cart at the beginning of her shift in the morning because staff were not assigned to the medication carts during night shift. She counted the cart she was assigned to, in the medication room in front of the camera, without any other staff present at the beginning and end of her shift. She typically signed the on-coming staff signature column when she completed the count but she had not signed the log at the beginning of her shift on 7/14/25. She never signed the off-going staff signature column on the log and indicated there were several dates with blanks. QMA 3 did not count with another staff member on several occasions because medications were only passed on her shift. The medication cart keys were not given to anyone at the end of her shift. She notified the DON if there was a discrepancy with the narcotic count, clocked out, and left the building. On 7/14/25 at 2:10 p.m., the DON indicated staff contacted her when an "as needed" medication was requested on			

	night shift so a nurse could come to the building to administer the medication since no one was assigned to the medication cart at night. Staff were required to count the controlled medication in the medication carts along with the other QMA/nurse on the other unit at the beginning and end of each shift. The "Controlled Substance Shift Change Log" was required to be signed by both staff members present during the controlled medication reconciliation. During rare occasions, when they had a staff "call in," the controlled medication count was completed without a second staff member and any discrepancies were reported to the DON. Staff were not required to have the DON assist with reconciliations during an absence. On 7/14/25, they were staffed with a QMA on the 100 Unit and a QMA on the 200 Unit. Both medication carts should have been counted with both QMAs and the log signed by both staff members when the count was completed at the beginning and end of their shift.			

On 7/15/25 at 12:28 p.m., QMA 4 indicated staff were required to complete a controlled medication count on their assigned medication cart alone at the beginning and end of their shift. She was on duty by herself for her shift.

On 7/15/25 at 12:34 p.m., the DON indicated the facility did not have a policy regarding shift to shift controlled medication reconciliation.

Based on record review and interview, the facility failed to ensure staff competency regarding shift to shift controlled substance reconciliation for 2 of 2 medication carts reviewed for medication administration and storage. (100 Unit and 200 Unit medication carts) This deficiency had the potential to affect 20 of 20 residents who received controlled medications from the 100 Unit and 200 Unit medication carts.

Findings include:

1. During a medication storage observation of the 200 Unit medication cart, accompanied by QMA 5, on 7/14/25 at 11:44 a.m., the "Controlled Substances Shift Change Log" was reviewed from 6/14/25 to 7/14/25. The following dates and times lacked shift to shift reconciliations of controlled medications:

	June and July 2025- 6/14/25: 7:00 a.m. and 7:00 p.m. 6/15/25: 7:00 a.m. and 7:00 p.m. 6/16/25: 7:00 p.m. 6/17/25: 7:00 p.m. 6/18/25: 7:00 a.m. and 7:00 p.m. 6/19/25: 7:00 a.m. and 7:00 p.m. 6/20/25: 7:00 a.m. and 7:00 p.m. 6/21/25: 7:00 a.m. and 7:00 p.m. 6/22/25: 7:00 p.m. 6/23/25: 7:00 p.m. 6/24/25: 7:00 p.m. 6/25/25: 7:00 a.m. and 7:00 p.m. 6/27/25: 7:00 a.m. and 7:00 p.m. 6/28/25: 7:00 a.m. and 7:00 p.m. 6/29/25: 7:00 a.m. and 7:00 p.m. 6/30/25: 7:00 a.m. and 7:00 p.m.			

	7/1/25: 7:00 a.m. and 7:00 p.m. 7/3/25: 7:00 a.m. and 7:00 p.m. 7/4/25: 7:00 p.m. 7/5/25: 7:00 a.m. and 7:00 p.m. 7/6/25: 7:00 a.m. and 7:00 p.m. 7/8/25: 7:00 a.m. and 7:00 p.m. 7/9/25: 7:00 a.m. and 7:00 p.m. 7/11/25: 7:00 a.m. and 7:00 p.m. 7/12/25: 7:00 a.m. and 7:00 p.m. 7/13/25: 7:00 a.m. and 7:00 p.m. 7/14/25: 7:00 a.m. None of the dates from 6/14/25 to 7/14/25 contained two staff member signatures during the narcotic reconciliation at the beginning and ending of the shifts. During an interview on 7/14/25 at 11:48 a.m., QMA 5 indicated he did not count the controlled substances with an other staff member. He counted the controlled substances by himself on his cart each shift and reported any discrepancies to the DON. The "Controlled Substances Shift Change Log" was blank for 7/14/25.			

	2. During a medication storage observation of the 100 Unit medication cart, accompanied by QMA 3, on 7/14/25 at 12:12 p.m., the "Controlled Substances Shift Change Log" was reviewed from 6/14/25 to 7/14/25. The following dates and times lacked shift to shift reconciliations of controlled medications: June and July 2025- 6/16/25: 7:00 a.m. and 7:00 p.m. 6/18/25: 7:00 a.m. 6/19/25: 7:00 a.m. and 7:00 p.m. 6/20/25: 7:00 a.m. and 7:00 p.m. 6/21/25: 7:00 p.m. 6/22/25: 7:00 a.m. and 7:00 p.m. 6/23/25: 7:00 a.m. and 7:00 p.m. 6/24/25: 7:00 a.m. and 7:00 p.m. 6/25/25: 7:00 a.m. and 7:00 p.m. 6/27/25: 7:00 a.m. and 7:00 p.m.			

	6/28/25: 7:00 a.m. and 7:00 p.m. 6/29/25: 7:00 a.m. and 7:00 p.m. 6/30/25: 7:00 a.m. 7/1/25: 7:00 a.m. and 7:00 p.m. 7/2/25: 7:00 a.m. 7/3/25: 7:00 a.m. and 7:00 p.m. 7/4/25: 7:00 a.m. 7/5/25: 7:00 a.m. and 7:00 p.m. 7/6/25: 7:00 a.m. and 7:00 p.m. 7/7/25: 7:00 a.m. and 7:00 p.m. 7/8/25: 7:00 a.m. and 7:00 p.m. 7/9/25: 7:00 a.m. and 7:00 p.m. 7/10/25: 7:00 a.m. and 7:00 p.m. 7/11/25: 7:00 a.m. and 7:00 p.m. 7/12/25: 7:00 a.m. 7/13/25: 7:00 a.m. 7/14/25: 7:00 a.m. None of the dates from 6/14/25 to 7/14/25 contained two staff member signatures during the narcotic reconciliation at the beginning and ending of the shifts. During an interview on 7/14/25			

	at 12:12 p.m., QMA 3 indicated she did the shift to shift narcotic count by herself when she took over the medication cart at the beginning of her shift in the morning because staff were not assigned to the medication carts during night shift. She counted the cart she was assigned to, in the medication room in front of the camera, without any other staff present at the beginning and end of her shift. She typically signed the on-coming staff signature column when she completed the count but she had not signed the log at the beginning of her shift on 7/14/25. She never signed the off-going staff signature column on the log and indicated there were several dates with blanks. QMA 3 did not count with another staff member on several occasions because medications were only passed on her shift. The medication cart keys were not given to anyone at the end of her shift. She notified the DON if there was a discrepancy with the narcotic count, clocked out, and left the building. On 7/14/25 at 2:10 p.m., the DON indicated staff contacted her when an "as needed" medication was requested on night shift so a nurse could come to the building to administer the medication since no one was assigned to the medication cart at night. Staff were required to count the			

	controlled medication in the medication carts along with the other QMA/nurse on the other unit at the beginning and end of each shift. The "Controlled Substance Shift Change Log" was required to be signed by both staff members present during the controlled medication reconciliation. During rare occasions, when they had a staff "call in," the controlled medication count was completed without a second staff member and any discrepancies were reported to the DON. Staff were not required to have the DON assist with reconciliations during an absence. On 7/14/25, they were staffed with a QMA on the 100 Unit and a QMA on the 200 Unit. Both medication carts should have been counted with both QMAs and the log signed by both staff members when the count was completed at the beginning and end of their shift. On 7/15/25 at 12:28 p.m., QMA 4 indicated staff were required to complete a controlled medication count on their assigned medication cart alone at the beginning and end of their shift. She was on duty by herself for her shift.			

	On 7/15/25 at 12:34 p.m., the DON indicated the facility did not have a policy regarding shift to shift controlled medication reconciliation.			
R 0304	Pharmaceutical Services - Deficiency 410 IAC 16.2-5-6(e) (e) Medicine or treatment cabinets or rooms shall be appropriately locked at all times except when authorized personnel are present. All Schedule II drugs administered by the facility shall be kept in individual containers under double lock and stored in a substantially constructed box, cabinet, or mobile drug storage unit. Based on observation and interview, the facility failed to ensure controlled medications were appropriately secured to prevent potential misappropriation of medications for 2 of 2 medication carts reviewed for medication storage. (100 Unit and 200 Unit medication carts) This deficiency had the potential to affect 20 of 20 residents who received controlled medications from the 100 Unit and 200 Unit medication carts. Findings include: 1. During a medication storage observation of the 200 Unit medication cart, accompanied	R 0304	Our current practice was continued with controlled medication storage. Our pharmacy representative gave information about the cart that the pharmacy provides to use for medication use. The controlled substances are under double lock with the system we have. The cart is in a secure medication room when not in use by the QMA,RN,LPN. This medication room is considered the first lock. This medication room is only accessible to the authorized personnel at all times and they must use their code to enter. The second lock is the keyed box that is located in the medication cart. The staff must use the cart key to enter this box. The medication cart keys are securely stored in the medication room when not in use by the QMA,RN,LPN. In our assisted living facility we do not always have an authorized person to hand off the keys to, this is the reason to store them in the secure medication room. Our medication room is under camera at all times and DON and Executive Director can look at anytime and recall information from this system if needed. With the new controlled substance sheet log and instruction sheet as noted in the attachments this will make very low risk or no risk for misappropriation of medication for our facility.	07/18/2025

by QMA 5, on 7/14/25 at 11:44 a.m., the controlled substances drawer on the 200 Unit medication cart contained controlled medications. The narcotic drawer was opened by QMA 5 with a key.

During an interview on 7/14/25 at 11:48 a.m., QMA 5 indicated he did not count narcotics with another staff member for verification. At the end of his shift the medication cart keys were placed on top of the medication cart inside the medication room. The QMAs and nurses had codes to enter the medication rooms.

2. During a medication storage observation of the 100 Unit medication cart, accompanied by QMA 3, on 7/14/25 at 12:12 p.m., the controlled substances drawer on the 200 Unit medication cart contained controlled medications. The narcotic drawer was opened by QMA 3 with a key.

During an interview on 7/14/25 at 12:12 p.m., QMA 3 indicated medications were only passed on the 7:00 a.m. to 7:00 p.m. shift. Controlled substances were counted alone and were not verified by a second staff member. No one was assigned to the medication carts on night shift since they only had CNAs working on night shift. She was unable to give the medication

cart keys to the next shift.

On 7/14/25 at 2:10 p.m., the DON indicated staff left the medication cart keys on top of the medication carts in the medication rooms at the end of their shift at 7:00 p.m. Nurses and QMAs have their own codes to enter the medication rooms where the carts are located with the keys on top of the carts. The DON was notified via telephone when an "as needed" medication was required after those hours. Then a nurse was sent in to the facility to administer the medications. In the event a QMA or Nurse came to the facility during their "off shift hours," their code would allow them into the medication rooms and they would have access to the controlled medications in the medication carts with the keys on top of the medication carts. This was a potential for misappropriation of medications.

On 7/5/25 at 12:34 p.m., the DON indicated the facility did not have a policy regarding the safe storage of controlled substances.

On 7/15/25 at 12:34 p.m. the Administrator indicated the staff were trained to keep the keys to the medications carts on top of the medication carts in the medication storage rooms while they were in the facility and

when they left the facility at the end of their shift. A total of seven QMAs and nurses had access to the medication storage rooms where the medication carts, along with the keys, were stored. This included the Administrator and the DON.

On 7/15/25 at 1:21 p.m., the Administrator indicated neither the camera footage nor the security system sent any notifications or alerts when someone entered their pass code and accessed the medication storage rooms. If a nurse or QMA came in during "off shift hours" and entered their pass code to the medication storage rooms, they would have access to the controlled medications in the medication carts and the keys. This would be considered unauthorized access to the residents' medications. It was a potential for misappropriation of residents' medications.

Based on observation and interview, the facility failed to ensure controlled medications were appropriately secured to prevent potential misappropriation of medications for 2 of 2 medication carts reviewed for medication storage. (100 Unit and 200 Unit medication carts) This deficiency had the potential to affect 20 of 20 residents who received controlled medications

from the 100 Unit and 200 Unit medication carts.

Findings include:

1. During a medication storage observation of the 200 Unit medication cart, accompanied by QMA 5, on 7/14/25 at 11:44 a.m., the controlled substances drawer on the 200 Unit medication cart contained controlled medications. The narcotic drawer was opened by QMA 5 with a key.

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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