STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155771	A. BUILDING 00 B. WING	04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
OTTERBEIN FRANKLIN SENIORLIFE COMM RES & COM CARE	1070 W JEFFERSON ST FRANKLIN, IN 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00455719, IN00456653, and IN00457076. Complaint IN00455719 - Federal/State deficiencies related to the allegations are cited at F602, F609, and F755. Complaint IN00456653 - No deficiencies related to the allegations are cited. Complaint IN00457076 - No deficiencies related to the allegations are cited. Survey dates: April 8 and 9, 2025 Facility number: 001127 Provider number: 155771 AIM number: 200247220 Census Bed Type: SNF/NF: 38 NF: 93 Residential: 136 Total: 267 Census Payor Type: Medicare: 13 Medicaid: 99 Other: 19 Total: 131 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed April 15, 2025.	F 0000	F000 The creation and submission of this Plan of Correction do not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or any violation of the regulation. This provider respectfully requests that this 2567 Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post-survey review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Shannon Logan	HFA	05/02/2025

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

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F 0602 SS=D Bldg. 00	483.12 Free from Misappropriation/Exploitation Based on observation, interview and record review, the facility failed to protect the resident's right to be free from misappropriation of residents' controlled medications for 2 of 3 residents reviewed for misappropriation. (Resident B, Resident C) Findings include: 1. During an interview on 4/8/25 at 1:42 p.m., Unit Manager (UM) 1 indicated during the last week of February 2025, a medication monitoring record (a document used by the facility to reconcile controlled medications) was found in a binder that it did not belong behind the nurse's station. The medication monitoring record was for Resident B and indicated on 2/14/25, Resident B should have had two oxycodone (prescription narcotic pain medication) 15 milligrams (mg) tablets remaining in the locked medication cart. The medication monitoring record was last used on 2/14/25. When UM 1 looked, there were no oxycodone tablets remaining in the packet. UM 1 reported the discrepancy to the Director of Nursing (DON) that day. The clinical record for Resident B was reviewed on 4/9/25 at 10:13 a.m. The diagnoses included, but were not limited to, cerebral palsy, spondylosis, contractures, and cervical disc disorder with myelopathy. A quarterly Minimum Data Set (MDS) assessment, dated 1/1/25, indicated Resident B was cognitively intact. A current physicians order, initiated on 4/12/23,	F 0602	F602 – Free from Misappropriation/Exploitation **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No other residents were affected. Resident C was interviewed by the Director of Social Services. An audit was completed on all narcotics to verify count accuracy. All nursing staff were educated by the UM and/or her designee on 3/4/2025 (attachment #1) and 3/17/2025 (attachment #2) regarding proper Narcotic Count and proper Narcotic Destruction. All staff were educated by the UM and/or her designee on misappropriation on 3/17/2025 (attachment #3). RN1 was suspended pending investigation and then put on the DNR list with the agency. DON was suspended pending investigation and then terminated upon completion of investigation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents who reside on HC3 have the potential to be affected. An audit was completed on all narcotics to verify count	04/11/2025

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	indicated give one oxycodone 15 mg tablet orally three times daily for pain. A Medication Monitoring Record, dated 2/10/25 through 2/14/25, indicated a packet of fifteen oxycodone 15 mg tablets were received from the pharmacy for Resident B. On 2/14/25, Resident B should have had two oxycodone 15 mg tablets left in the medication packet. The monitoring record lacked any documentation of waste, spoilage, nor disposition of the remaining two doses of oxycodone 15 mg. On 4/9/25 at 9:20 a.m., the Administrator provided a copy of a facility disciplinary action form, dated 3/19/25, and indicated this was the disciplinary action taken when the Director of Nursing (DON) informed the Administrator that he was made aware of an allegation of misappropriation of Resident B's controlled substances but did not report the information to the Administrator. A review of the disciplinary action form indicated the DON was suspended pending investigation and then terminated for not reporting an allegation of misappropriation on 2/25/25. 2. On 4/8/25 at 10:18 a.m., the Administrator provided a copy of a facility reportable incident, dated 3/17/25 at 11:01 a.m. A review of the reportable incident indicated Resident C alleged that RN 1 had not been administering her oxycodone 15 mg, but instead had been administering allergy pills to Resident C. On 4/18/25 at 10:18 a.m., the Administrator provided the investigation into the misappropriation of resident property. The investigation included, but was not limited to: - A typed and signed staff statement, dated		accuracy. Social Services obtained a list of all residents who are on a prescribed narcotic and interviewed each of those residents to see if they have had any issues with receiving his or her medication. No further residents were identified to have been affected. All nursing staff were educated by the UM and/or her designee on 3/4/2025 (attachment #1) and 3/17/2025 (attachment #2) regarding proper Narcotic Count and proper Narcotic Destruction. All staff were educated by the UM and/or her designee on misappropriation on 3/17/2025 (attachment #3). RN1 was suspended pending investigation and then put on the DNR list with the agency. DON was suspended pending investigation and then terminated upon completion of investigation. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** DON was not following facility policy and was terminated on 3/18/2025. Routine audits by DON have been added to DON's weekly duties. Weekly Narcotic Audits have been added to our Achieving Clinical Excellence (ACE) tracking spreadsheet. ACE sheet is to be audited monthly by the Corporate AVP Consultant. **How will the corrective**	

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	3/6/25, indicated LPN 1 found an unknown small white pill taped into Resident C's packet of oxycodone 15 mg. LPN 1 recognized the unknown pill because the oxycodone were small green tablets, and the unknown medication was a small white tablet. LPN 1 immediately went to UM 1 to report and the DON walked up, so LPN 1 reported to the DON. The statement was signed by LPN 1. - A typed and signed staff statement, dated 3/13/25 at approximately 12:45 p.m., indicated RN 2 reconciled the controlled substances with RN 1. When the reconciliation was completed, RN 2 noticed a medication cup on top of the medication cart that contained a small amount of pink liquid. When RN 2 asked RN 1 what was the pink liquid, RN 1 indicated the pink liquid was Resident C's oxycodone 15 mg that had to be destroyed. RN 2 watched RN 1 destroy the pink liquid, but later recognized Resident C's oxycodone 15 mg was green not pink. RN 2 reported to UM 1 and UM 1 immediately called the DON and reported this. - A typed and signed staff statement, dated 3/17/25, indicated Resident C told LPN 1 when she asked RN 1 for oxycodone 15 mg, RN 1 had been administering a small white tablet of an unknown medication. This was reported to UM 1 immediately. The clinical record for Resident C was reviewed on 4/8/25 at 10:41 a.m. The diagnoses included, but were not limited to, anxiety, chronic obstructive pulmonary disorder, and chronic respiratory failure. A quarterly MDS assessment, dated 2/7/25, indicated Resident C was cognitively intact. A current physicians order, initiated on 1/30/25,		**action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Monitoring of the Narcotic MAR is ongoing. Audits to ensure that narcotics are accounted for and disposed of properly were completed on 3/20/2025, 3/27/2025, 4/1/2025, 4/8/2025, 4/15/2025, 4/22/2025, and 4/30/2025 (attachment #4 and attachment #5). Medication Cart Audits will be completed at random, weekly. The DON will bring audits to the Quality Assurance Meeting for three months to monitor compliance; at that time, the QA Committee can choose to discontinue bringing audits to the QAPI Meeting, but DON will continue auditing indefinitely. The QA Committee will identify any trends or patterns and make recommendations to revise the process as indicated. The DON is responsible for the implementation and monitoring of this plan. **By what date the systemic changes for each deficiency will be completed?** 4/11/2025	

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	indicated give one oxycodone 15 mg orally every six hour as needed for moderate to severe pain. During an interview on 4/8/25 at 12:58 p.m., Resident C indicated when she would request an oxycodone 15 mg tablet for pain, RN 1 would give her a different unknown medication instead. Resident C had become concerned because she would get very tired and sleepy whenever RN 1 gave her the oxycodone but that was not her normal reaction to the oxycodone. Resident C started paying attention to what RN 1 would give to her when she requested her oxycodone. The oxycodone 15 mg were small green pills but when Resident C would request the oxycodone from RN 1, RN 1 would bring a "little white pill shaped like a football". During an interview on 4/8/25 at 1:37 p.m., the Administrator indicated on approximately 3/6/25, LPN 1 made the Director of Nursing (DON) aware that one of Resident C's oxycodone 15 mg tablets had been removed from the pill packet and an unknown pill was placed into the packet then the packet was taped shut. During an interview on 4/8/25 at 2:20 p.m., LPN 1 indicated on 3/6/25, she found a little white pill of an unknown medication taped into Resident C's packet of oxycodone. She recognized the white pill because Resident C's oxycodone was a small green pill. LPN 1 reported the information to the DON immediately. On 4/9/25 at 9:20 a.m., the Administrator provided a copy of a facility disciplinary action form, dated 3/19/25, and indicated this was the disciplinary action taken when the Director of Nursing (DON) informed the Administrator that he was made aware of allegations of misappropriation of			

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	Resident B's oxycodone 15 mg, on 2/25/25, and Resident C's oxycodone, on 3/6/25, and on 3/13/25, but did not report the information to the Administrator until 3/17/25. A review of the disciplinary action form indicated the DON was suspended pending investigation and then terminated, on 3/19/25, for not reporting allegations of misappropriation. On 4/8/25 at 10:18 a.m., the Administrator provided a copy of a facility policy, titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/26/22, and indicated this was the current policy used by the facility. A review of the policy indicated residents have the right to be free from misappropriation of property. This citation relates to Complaint IN00455719. 3.1-28(a)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on interview and record review, the facility failed to report allegations of misappropriation of residents' narcotic (prescription controlled substance used to treat pain) pain medications to the Administrator for 2 of 3 residents reviewed for misappropriation. (Resident B, Resident C) Findings include: 1. During an interview on 4/8/25 at 1:42 p.m., Unit Manager (UM) 1 indicated during the last week of February 2025, a medication monitoring record was found in a binder behind the nurse's station. The medication monitoring record was for Resident B and indicated Resident B should have	F 0609	F609 – Reporting of Alleged Violations **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No other residents were affected. Resident C was interviewed by the Director of Social Services. An audit was completed on all narcotics to verify count accuracy. All nursing staff were educated by the UM and/or her designee on 3/4/2025 (attachment	04/11/2025

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	had two oxycodone (prescription narcotic pain medication) 15 milligrams (mg) tablets remaining in the locked medication cart. When UM 1 looked, there were no oxycodone tablets remaining in the packet. UM 1 reported this to the Director of Nursing (DON) that day. 2. On 4/8/25 at 10:18 a.m., the Administrator provided a copy of a facility reportable incident, dated 3/17/25 at 11:01 a.m. A review of the reportable incident indicated Resident C alleged that RN 1 had not been administering her oxycodone but instead had been administering allergy pills. During an interview on 4/8/25 at 1:37 p.m., the Administrator indicated on approximately 3/13/25, LPN 1 made the DON aware that a one of Resident C's oxycodone 15 mg tablets had been removed from the pill packet and an unknown pill was placed into the packet and the packet had been taped shut. The DON did not report this information to the Administrator until 3/17/25. The DON was terminated for not reporting this information to the Administrator immediately. During an interview, on 4/8/25 at 2:20 p.m. LPN 1 indicated she found a little white pill of an unknown medication taped into Resident C's packet of oxycodone. She recognized the white pill because Resident C's oxycodone was a small green pill. LPN 1 reported the information to the DON immediately. On 4/8/25 at 10:18 a.m., the Administrator provided a copy of a facility policy, titled Abuse, Mistreatment, Neglect, Exploitation and Misappropriation of Resident Property, dated 10/26/22, and indicated this was the current policy used by the facility. A review of the policy		#1) and 3/17/2025 (attachment #2) regarding proper Narcotic Count and proper Narcotic Destruction. All staff were educated by the UM and/or her designee on misappropriation on 3/17/2025 (attachment #3). RN1 was suspended pending investigation and then put on the DNR list with the agency. DON was suspended pending investigation and then terminated upon completion of investigation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents who reside on HC3 have the potential to be affected. An audit was completed on all narcotics to verify count accuracy. Social Services obtained a list of all residents who are on a prescribed narcotic and interviewed each of those residents to see if they have had any issues with receiving his or her medication. No further residents were identified to have been affected. All nursing staff were educated by the UM and/or her designee on 3/4/2025 (attachment #1) and 3/17/2025 (attachment #2) regarding proper Narcotic Count and proper Narcotic Destruction. All staff were educated by the UM and/or her designee on misappropriation on 3/17/2025 (attachment #3).	

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	indicated all allegation of misappropriation of a resident's property should be reported to the state health department immediately. This citation relates to Complaint IN00455719. 3.1-28(c)		RN1 was suspended pending investigation and then put on the DNR list with the agency. DON was suspended pending investigation and then terminated upon completion of investigation. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** An all-staff in-service on what to report and when to report was presented to all staff on 3/17/2025 by the UM and/or her designee. The Executive Director and Administrator will have designated, monthly one-on-one meetings with any staff member who wishes to meet and discuss anything they wish to bring forth to Administration. The DON and/or her designee will hold designated, monthly staff meetings on each unit to discuss anything they wish to bring forth to Administration. Transcription of these meetings will be presented to the QAPI team once a quarter. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** An all-staff in-service on what to report and when to report was presented to all staff on 3/17/2025 by the UM and/or her designee. The Executive Director and	

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			Administrator will have designated, monthly one-on-one meetings with any staff member who wishes to meet and discuss anything they wish to bring forth to Administration. The DON and/or her designee will hold designated, monthly staff meetings on each unit to discuss anything they wish to bring forth to Administration. Transcription of these meetings will be presented to the QAPI team once a quarter. **By what date the systemic changes for each deficiency will be completed?** 4/11/2025	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, interview, and record review, the facility failed to ensure controlled medication records were accurately reconciled to account for all controlled drugs for 2 of 3 residents reviewed for misappropriation of property. (Resident B, Resident C) Findings include: 1. During an interview on 4/8/25 at 1:42 p.m., Unit Manager (UM) 1 indicated during the last week of February 2025, a medication monitoring record (a document used by the facility to reconcile the number of controlled substances each resident had) was found in a binder behind the nurse's station. The document did not belong in the binder. The medication monitoring record was for Resident B and indicated Resident B should have had two oxycodone (controlled drug to treat pain)	F 0755	F755 – Pharmacy Srvcs/Procedures/Pharmacist/Records **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No other residents were affected. Resident C was interviewed by the Director of Social Services. An audit was completed on all narcotics to verify count accuracy. All nursing staff were educated by the UM and/or her designee on 3/4/2025 (attachment #1) and 3/17/2025 (attachment #2) regarding proper Narcotic Count and proper Narcotic Destruction.	04/11/2025

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	15 milligrams (mg) tablets remaining in the locked medication cart. The medication monitoring record was last used, on 2/14/25. When UM 1 reviewed the packet of Resident B's oxycodone 15 mg, there were no oxycodone tablets remaining in the packet. The clinical record for Resident B was reviewed, on 4/9/25 at 10:13 a.m. Diagnoses included, but were not limited to, cerebral palsy, spondylosis, contractures, and cervical disc disorder with myelopathy. A current physicians order, initiated 4/12/23, indicated give one oxycodone 15 mg tablet orally three times daily for pain. During a medication reconciliation observation on 4/9/25 at 8:56 a.m., Qualified Medication Aide (QMA) 2 did not remove each controlled medication packets, so that both staff that reconciled the controlled drugs were able to observe the controlled medication in each packet. At that time, QMA 2 indicated when a controlled medication was delivered, the nursing staff should ensure the controlled medications were reconciled. The medication monitoring records were then placed in the controlled drug binder on each medication cart. Each time a nurse or QMA removed a controlled medication from the cart, that person should have signed the medication monitoring record, along with the date and time the medication was given, the amount that was on hand before administering the medication, the amount of medication administered, and the amount of the medication that remained in the cart. If a controlled medication had to be wasted, the staff should document that in the record of waste box and when a resident discharged, the amount of remaining controlled medication in the		All staff were educated by the UM and/or her designee on misappropriation on 3/17/2025 (attachment #3). RN1 was suspended pending investigation and then put on the DNR list with the agency. DON was suspended pending investigation and then terminated upon completion of investigation. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents who reside on HC3 have the potential to be affected. An audit was completed on all narcotics to verify count accuracy. On 3/17/2025, Social Services obtained a list of all residents who are on a prescribed narcotic and interviewed each of those residents to see if they have had any issues with receiving his or her medication. No further residents were identified to have been affected. All nursing staff were educated by the UM and/or her designee on 3/4/2025 (attachment #1) and 3/17/2025 (attachment #2) regarding proper Narcotic Count and proper Narcotic Destruction. All staff were educated by the UM and/or her designee on misappropriation on 3/17/2025 (attachment #3). RN1 was suspended pending investigation and then put on the DNR list with the agency. DON	

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	packet should have been documented in the disposition of remaining doses box. The monitoring records were used by the staff during shift change to reconcile the controlled medications. QMA 2 had not thought about both staff members observing the number of controlled drugs in each packet during a reconciliation. On 4/9/25 at 9:20 a.m., the Administrator provided a copy of a document, titled Medication Monitoring Record, dated 2/10/25 through 2/14/25. At the top of the monitoring record was a label that indicated a packet of 15 oxycodone 15 mg was delivered for Resident B on 2/10/25. Just below the label was a line that indicated "Received by: (print name), licensed nurse" and "Amount Received". Just below that was a graph with seven tabs that ran across the document. The tabs were labeled from left to right, "Name of Person Giving", "Initial if in Error", "Date MM/DD/YY [month, day, year]", "Time AM/PM", amount on hand, amount given, and amount remaining. Under the labeled boxes were lines that ran across the document, numbered 1 (first line) through 20 (last line). Just below that was a box labeled record of waste and spoilage and below that another box labeled disposition of remaining doses. A review of the information documented on the medication monitoring document indicated: Received by: (print name), Licensed Nurse like - one signature and one printed name. Date received line - 2/10/25. Amount received line - 15 tablets - Line 1 - signature, 2/10/25 at 12:00 p.m., 15 tablets on hand, 1 tablet administered, 14 tablets remained.		was suspended pending investigation and then terminated upon completion of investigation. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur?** Monitoring of the Narcotic MAR is ongoing. Audits to ensure that narcotics are accounted for and disposed of properly were completed on 3/20/2025, 3/27/2025, 4/1/2025, 4/8/2025, 4/15/2025, 4/22/2025, and 4/30/2025 (attachment #4 and attachment #5). Medication Cart Audits will be completed at random, weekly. The DON will bring audits to the Quality Assurance Meeting for three months to monitor compliance; at that time, the QA Committee can choose to discontinue bringing audits to the QAPI Meeting, but DON will continue auditing indefinitely. The QA Committee will identify any trends or patterns and make recommendations to revise the process as indicated. The DON is responsible for the implementation and monitoring of this plan. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Monitoring of the Narcotic MAR is	

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	155771	A. BUILDING 00 B. WING	04/09/2025

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	- Line 2 - signature, 2/10/25 at 10:00 p.m., 14 tablets on hand, 1 tablet administered, 13 tablets remained. - Line 3 - signature, no date documented at 6:00 a.m., no on hand documented, no amount given documented, 12 tablets remained. - Line 4 - signature, 2/11/25 at 12:00 p.m., 12 tablets on hand, 1 tablet administered, 11 tablets remained. - Line 5 - signature, illegible date, no time documented, no on hand documented, no amount administered documented, 10 tablets remained. - Line 6 - no signature documented, no date documented at 6:00 a.m., no on hand documented, no amount given documented, 9 tablets remained. - Line 7 - signature, 2/12/25 at 12:00 p.m., 9 tablets on hand, 1 tablet administered, 8 tablets remained. - Line 8 - signature, 2/12/25 at 10:00 p.m., 8 tablets on hand, 1 tablet administered, 7 tablets remained. - Line 9 - signature, 2/13/25 at 6:00 a.m., 7 tablets on hand, 1 tablet administered, 6 tablets remained, and a line drawn through the documentation on line 9. - Line 10 - signature, 2/13/25 at 6:00 a.m., 6 tablets on hand, 1 tablet administered, 5 tablets remained. - Line 11 - signature, 2/13/25 at 12:00 p.m., 5 tablets on hand, 1 tablet administered, 4 tablets remained. - Line 12 - signature, 2/13/25 at 10:00 p.m., 4 tablets		ongoing. Audits to ensure that narcotics are accounted for and disposed of properly 3/20/2025, 3/27/2025, 4/1/2025, 4/8/2025, 4/15/2025, 4/22/2025, and 4/30/2025 (attachment #4 and attachment #5). Audits will be completed randomly for 4 weeks, then at the discretion of the QA/QAPI Committee. The Unit Manager of HC3 will bring audits to the Quality Assurance Meeting. The QA Committee will identify any trends or patterns and make recommendations to revise the process as indicated. The DON and Unit Manager are responsible for the implementation and monitoring of this plan. **By what date the systemic changes for each deficiency will be completed?** 4/11/2025	

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	on hand, 1 tablet administered, 3 tablets remained. - Line 13 - signature, 2/14/25 at 6:00 a.m., 3 tablets on hand, 1 tablet administered, 2 tablets remained. The medication monitoring record, dated 2/10/25 through 2/14/25, lacked sufficient documentation to account for the controlled drug administrations on line 3, line 5, line 6, line 9 when a line was drawn through the documentation on line 9, and no documentation to account for the two remaining oxycodone tablets that remained, on 2/14/25. 2. On 4/8/25 at 10:18 a.m., the Administrator provided a copy of a facility reportable incident, dated 3/17/25 at 11:01 a.m. A review of the reportable incident indicated Resident C alleged that RN 1 had not been administering her oxycodone 15 mg but instead had been administering allergy pills to Resident C. During an interview on 4/8/25 at 2:20 p.m., LPN 1 indicated, on 3/6/25 at approximately 12:00 p.m. (approximately 4 hours after the shift started), she found a little white pill of an unknown medication taped into Resident C's packet of oxycodone 15 mg. She recognized the white pill because Resident C's oxycodone tablets were small green pills. LPN 1 didn't think she saw the oxycodone pill packet when she reconciled the controlled substances that morning. The clinical record for Resident C was reviewed on 4/8/25 at 10:41 a.m. The diagnoses included, but were not limited to, anxiety, chronic obstructive pulmonary disorder, and chronic respiratory failure. A current physicians order, initiated 1/30/25,			

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	indicated give one oxycodone 15 mg orally every six hour as needed for moderate to severe pain. On 4/9/25 at 9:20 a.m., the Administrator provided a undated copy of a facility policy, titled Narcotic Discrepancies, and indicated this was the current policy used by the facility. A review of the policy indicated the facility would maintain a signed medication count record. This citation relates to Complaint IN00455719. 3.1-25(e)(2)			