STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155242	A. BUILDING _____ B. WING _____	C 07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF MUNCIE	4301 N WALNUT ST MUNCIE, IN 47303

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00461866, IN00461690 and IN00460801. Complaint IN00461866 - Federal/state deficiencies related to the allegations are cited at F609, F610, and F755. Complaint IN00461690 - No deficiencies related to the allegation are cited. Complaint IN00460801 - No deficiencies related to the allegation are cited. Survey dates: July 1, 2, and 3, 2025 Facility number: 000146 Provider number: 155242 AIM number: 100291200 Census Bed Type: SNF/NF: 120 Total: 120 Census Payor Type: Medicare: 5 Medicaid: 97 Other: 18 Total: 120 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed July 8, 2025.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse,	F 609		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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neglect, exploitation, or mistreatment, the facility must:

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to report a suspected drug diversion to the appropriate regulatory agencies for 4 of 6 residents reviewed for narcotic medication administration. (Residents H, J, K, and M)

Findings include:

1. Resident H's record was reviewed on 7/2/25 at 10:45 a.m. Diagnoses included migraine,

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osteoarthritis (bone pain), fibromyalgia (nerve pain) , and chronic pain syndrome.

Physician orders included oxycodone-acetaminophen (narcotic pain medication) 7.5-325 milligram (mg) give one tablet by mouth every four hours only while awake.

Resident H's electronic medication administration record (eMAR) indicated she received a dose of oxycodone on 6/2/25 scheduled at 6:00 p.m. but was charted at 8:22 p.m. with the comment "per lpn" by LPN 15. A dose of oxycodone scheduled for 6/2/25 at 10:00 p.m. was charted on 6/3/25 at 9:39 a.m. as not given due to condition, signed by QMA 20. A dose scheduled for 6/3/25 at 2:00 a.m. was charted as refused on 6/3/25 at 4:10 a.m. by QMA 2 due to the resident sleeping.

Resident H's narcotic sign out sheet, provided by the Corporate Nurse Consultant on 7/2/25 at 10:36 a.m., indicated LPN 15 signed out a dose of oxycodone-acetaminophen on 6/2/25 at 10:00 p.m. with forty-two tablets remaining. The times of 12:00 a.m. and 2:00 a.m. were printed on the narcotic sheet, but had no signature, amount given, or amount remaining. A photograph of the resident's narcotic card provided concurrently with the count sheet indicated thirty-eight tablets remained. Thirty-nine oxycodone should have remained.

During an interview with the Corporate Nursing Consultant on 7/3/25 at 10:02 a.m., she indicated that during an interview with Resident H, the resident indicated LPN 15 gave her pain medication early and she received two oxycodone tablets.

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During an interview with Resident H, on 7/3/25 at 10:26 a.m., she was unable to recall being given medications early on 6/2/25 and 6/3/25.

2. Resident K's record was reviewed on 7/2/25 at 10:42 a.m. Diagnoses included spina bifida (spinal cord defect), bilateral above knee amputations, and chronic pain syndrome.

Physician orders included oxycodone-acetaminophen 5-325 mg give 1 tablet by mouth every 4 hours while awake.

The resident's eMAR indicated doses of oxycodone-acetaminophen scheduled for 6/3/25 at 12:00 a.m. was administered by QMA 2 at 3:21 a.m. due to "patient care", and he refused his scheduled 4:00 a.m. dose on 6/3/25.

The resident's narcotic sheet, provided by the Corporate Nurse Consultant on 7/2/25 at 10:36 a.m., indicated doses were signed out by LPN 15 on 6/2/25 at 8:00 p.m., 6/3/25 at 12:00 a.m. with the comment "not given" signed by LPN 16, and 6/3/25 at 4:00 a.m. with the comment "not given" signed by LPN 16 and 6/3/25 at 2:00 a.m. by QMA 2.

A medication card for comparison was not provided prior to exit.

3. Resident L's record was reviewed on 7/2/25 at 11:58 a.m. Diagnoses included COPD, peripheral vascular disease, and chronic pain syndrome.

Physician orders included oxycodone 5 mg give 5 mg by mouth every eight hours at 6:00 a.m., 2:00 p.m., and 10:00 p.m.

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The resident's eMAR indicated doses of oxycodone scheduled on 6/2/25 at 10:00 p.m. were given on 6/3/25 at 4:00 a.m. and a dose scheduled 6/3/25 at 6:00 a.m. was given by LPN 16.

The resident's narcotic count sheet provided by the Corporate Nurse Consultant on 7/2/25 at 10:36 a.m. indicated a dose of oxycodone was signed out by LPN 16 on 6/3/25 at 1:00 a.m. and 6/3/25 at 6:00 a.m.

During an interview with LPN 16 on 7/3/25 at 9:43 a.m. she indicated a dose of oxycodone for resident L was due at 12:00 a.m. She took the medication out of the card and indicated QMA 19 gave the medication. She was unable to recall which medications she administered and which medications QMA 19 administered on 6/3/25. LPN 16 indicated it was not appropriate for someone to remove a medication from the card and another person administer the medication.

4. Resident M's record was reviewed on 7/2/25 at 10:47 a.m. Diagnoses included COPD, opioid use, restless legs syndrome, other chronic pain, and radiculopathy (nerve pain) of the lumbar (lower back) region.

Physician orders included, oxycodone-acetaminophen 10-325 mg give 1 tablet every 4 hours as needed for pain.

The resident's eMAR indicated she was given doses of oxycodone-acetaminophen on 6/2/25 at 4:51 p.m. and 6/3/25 at 10:22 a.m.

The resident's narcotic count sheet provided by

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the Corporate Nurse Consultant on 7/3/25 at 10:08 a.m., indicated doses of oxycodone-acetaminophen were signed out by LPN 15 on 6/2/25 at 10:00 p.m., 6/3/25 at 2:00 a.m., and 6/3/25 at 6:00 a.m.

A medication card for comparison was not provided prior to exit.

During an interview on 7/3/2025 at 10:05 a.m., the Corporate Nurse Consultant indicated when she was informed of the concern of missing medications, she reviewed the medication carts for the 200 and 400 Halls and the narcotic count books. The narcotic counts were off, but they thought the discrepancies could be explained because the medications had been documented as signed out early. The Corporate RN did not compare the narcotic sheets with the Medication Administration Record during the investigation, nor report the concerns to the appropriate regulatory agencies.

During an interview with the Corporate Nurse Consultant on 7/3/25 at 10:53 a.m., she indicated no medication reconciliation was performed for Resident M for the doses signed out on 6/2/25 at 10:00 p.m., 6/3/25 at 2:00 a.m., and 6/3/25 at 6:00 a.m.

During an interview on 7/3/2025 at 7:41 a.m., QMA 2 indicated during the third shift on 6/2/2025 a nurse went home due to illness. At approximately between 5:00 a.m. and 5:30 a.m., she counted the medication cart for the 400 Hall with LPN 16. The narcotic count was not correct and she believed some medications were missing. QMA 2 indicated it appeared LPN 15 had signed out some of the mediations in

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advance. LPN 16 and QMA 2 reported the discrepancies to the unit manager.

During an interview on 7/2/2025 at 9:48 a.m., LPN 16 indicated she was informed by CNA 17 that none of the medication on the 200 Hall had been passed and residents were complaining. Upon finding the nurse for that hall (LPN 15), LPN 16 found her in the bathroom. Her speech was slurred and she appeared disheveled, swaying and unable to stand up straight. LPN 15 was sent home and gave the medication cart keys to LPN 16. LPN 16 did not count the narcotic boxes due to it being a busy night.

During an interview on 7/2/2025 at 9:53 a.m., Unit Manager 18 indicated on 6/3/2025 at 5:15 a.m. she received a phone call from LPN 16 stating that LPN 15 had been sent home and the narcotic count was "off". The Unit Manager was en route to the facility and indicated she would investigate the concern when she arrived. The Unit Manager investigated the medication carts for the 200 and 400 Halls and found the counts to be "off". The Unit Manager interviewed alert and oriented residents, and reported the concern to the Corporate Nurse at 6:22 a.m.

Review of a current policy, dated 5/27/2016, titled "Abuse, Neglect and Misappropriation of Property" was provided by the DON on 7/1/2025 at 12:04 p.m. The policy indicated the following: "...It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation injuries of unknown origin, and misappropriation of resident property, and to assure that all alleged violations of federal or State laws which involve abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property

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F 609	Continued From page 7 are investigated, and reported immediately to the Facility Administrator, the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and Sate law. ....***Reporting Guidelines:*** .... Any allegation of neglect, exploitation, mistreatment or misappropriation of resident property must be reported to the State Regulatory Agency within 24 hours. ...." Cross reference F755. This citation relates to complaints IN00461866.	F 609		
F 610 SS=D	3.1-28(c) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 610		

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Based on interview and record review, the facility failed to conduct a through investigation of an suspected drug diversion for 4 of 6 residents reviewed for medication admnistration. (Residents H, K, L,and M)

Findings include:

1. Resident H's record was reviewed on 7/2/25 at 10:45 a.m. Diagnoses included migraine, osteoarthritis (bone pain), fibromyalgia (nerve pain) , and chronic pain syndrome.

Physician orders included oxycodone-acetaminophen (narcotic pain medication) 7.5-325 milligram (mg) give one tablet by mouth every four hours only while awake.

Resident H's electronic medication administration record (eMAR) indicated she received a dose of oxycodone on 6/2/25 scheduled at 6:00 p.m. but was charted at 8:22 p.m. with the comment "per lpn" by LPN 15. A dose of oxycodone scheduled for 6/2/25 at 10:00 p.m. was charted on 6/3/25 at 9:39 a.m. as not given due to condition, signed by QMA 20. A dose scheduled for 6/3/25 at 2:00 a.m. was charted as refused on 6/3/25 at 4:10 a.m. by QMA 2 due to the resident sleeping.

Resident H's narcotic sign out sheet, provided by the Corporate Nurse Consultant on 7/2/25 at 10:36 a.m., indicated LPN 15 signed out a dose of oxycodone-acetaminophen on 6/2/25 at 10:00 p.m. with forty-two tablets remaining. The times of 12:00 a.m. and 2:00 a.m. were printed on the narcotic sheet, but had no signature, amount given, or amount remaining. A photograph of the resident's narcotic card provided concurrently

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with the count sheet indicated thirty-eight tablets remained. Thirty-nine oxycodone should have remained.

During an interview with the Corporate Nursing Consultant on 7/3/25 at 10:02 a.m., she indicated that during an interview with Resident H, the resident indicated LPN 15 gave her pain medication early and she received two oxycodone tablets.

During an interview with Resident H, on 7/3/25 at 10:26 a.m., she was unable to recall being given medications early on 6/2/25 and 6/3/25.

2. Resident K's record was reviewed on 7/2/25 at 10:42 a.m. Diagnoses included spina bifida (spinal cord defect), bilateral above knee amputations, and chronic pain syndrome.

Physician orders included oxycodone-acetaminophen 5-325 mg give 1 tablet by mouth every 4 hours while awake.

The resident's eMAR indicated doses of oxycodone-acetaminophen scheduled for 6/3/25 at 12:00 a.m. was administered by QMA 2 at 3:21 a.m. due to "patient care", and he refused his scheduled 4:00 a.m. dose on 6/3/25.

The resident's narcotic sheet, provided by the Corporate Nurse Consultant on 7/2/25 at 10:36 a.m., indicated doses were signed out by LPN 15 on 6/2/25 at 8:00 p.m., 6/3/25 at 12:00 a.m. with the comment "not given" signed by LPN 16, and 6/3/25 at 4:00 a.m. with the comment "not given" signed by LPN 16 and 6/3/25 at 2:00 a.m. by QMA 2.

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A medication card for comparison was not provided prior to exit.

3. Resident L's record was reviewed on 7/2/25 at 11:58 a.m. Diagnoses included COPD, peripheral vascular disease, and chronic pain syndrome.

Physician orders included oxycodone 5 mg give 5 mg by mouth every eight hours at 6:00 a.m., 2:00 p.m., and 10:00 p.m.

The resident's eMAR indicated doses of oxycodone scheduled on 6/2/25 at 10:00 p.m. were given on 6/3/25 at 4:00 a.m. and a dose scheduled 6/3/25 at 6:00 a.m. was given by LPN 16.

The resident's narcotic count sheet provided by the Corporate Nurse Consultant on 7/2/25 at 10:36 a.m. indicated a dose of oxycodone was signed out by LPN 16 on 6/3/25 at 1:00 a.m. and 6/3/25 at 6:00 a.m.

During an interview with LPN 16 on 7/3/25 at 9:43 a.m. she indicated a dose of oxycodone for resident L was due at 12:00 a.m. She took the medication out of the card and indicated QMA 19 gave the medication. She was unable to recall which medications she administered and which medications QMA 19 administered on 6/3/25. LPN 16 indicated it was not appropriate for someone to remove a medication from the card and another person administer the medication.

4. Resident M's record was reviewed on 7/2/25 at 10:47 a.m. Diagnoses included COPD, opioid use, restless legs syndrome, other chronic pain, and radiculopathy (nerve pain) of the lumbar (lower back) region.

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Physician orders included, oxycodone-acetaminophen 10-325 mg give 1 tablet every 4 hours as needed for pain.

The resident's eMAR indicated she was given doses of oxycodone-acetaminophen on 6/2/25 at 4:51 p.m. and 6/3/25 at 10:22 a.m.

The resident's narcotic count sheet provided by the Corporate Nurse Consultant on 7/3/25 at 10:08 a.m., indicated doses of oxycodone-acetaminophen were signed out by LPN 15 on 6/2/25 at 10:00 p.m., 6/3/25 at 2:00 a.m., and 6/3/25 at 6:00 a.m.

A medication card for comparison was not provided prior to exit.

During an interview on 7/3/2025 at 10:05 a.m., the Corporate Nurse Consultant indicated when she was informed of the concern of missing medications, she reviewed the medication carts for the 200 and 400 Halls and the narcotic count books. The narcotic counts were off, but they thought the discrepancies could be explained because the medications had been documented as signed out early. The Corporate RN did not compare the narcotic sheets with the Medication Administration Record during the investigation, nor report the concerns to the appropriate regulatory agencies.

During an interview with the Corporate Nurse Consultant on 7/3/25 at 10:53 a.m., she indicated no medication reconciliation was performed for Resident M for the doses signed out on 6/2/25 at 10:00 p.m., 6/3/25 at 2:00 a.m., and 6/3/25 at 6:00 a.m.

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F 610	Continued From page 12 Cross reference F609 and F755. This citation relates to complaints IN00461866. 3.1-28(d)	F 610		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in	F 755		

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	155242	A. BUILDING _____ B. WING _____	C 07/03/2025

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SIGNATURE HEALTHCARE OF MUNCIE	4301 N WALNUT ST MUNCIE, IN 47303

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order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure controlled medication administration was accurately documented and medication amounts reconciled according to facility policy for 4 of 6 residents reviewed for medications (Residents H, K, L, and M)

Findings included:

1. Resident H's record was reviewed on 7/2/25 at 10:45 a.m. Diagnoses included migraine, osteoarthritis (bone pain), fibromyalgia (nerve pain) , and chronic pain syndrome.

Physician orders included oxycodone-acetaminophen (narcotic pain medication) 7.5-325 milligram (mg) give one tablet by mouth every four hours only while awake.

Resident H's electronic medication administration record (eMAR) indicated she received a dose of oxycodone on 6/2/25 scheduled at 6:00 p.m. but was charted at 8:22 p.m. with the comment "per lpn" by LPN 15. A dose of oxycodone scheduled for 6/2/25 at 10:00 p.m. was charted on 6/3/25 at 9:39 a.m. as not given due to condition, signed by QMA 20. A dose scheduled for 6/3/25 at 2:00 a.m. was charted as refused on 6/3/25 at 4:10 a.m. by QMA 2 due to the resident sleeping.

Resident H's narcotic sign out sheet, provided by the Corporate Nurse Consultant on 7/2/25 at 10:36 a.m., indicated LPN 15 signed out a dose of oxycodone-acetaminophen on 6/2/25 at 10:00

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p.m. with forty-two tablets remaining. The times of 12:00 a.m. and 2:00 a.m. were printed on the narcotic sheet, but had no signature, amount given, or amount remaining. A photograph of the resident's narcotic card provided concurrently with the count sheet indicated thirty-eight tablets remained. Thirty-nine oxycodone should have remained.

During an interview with the Corporate Nursing Consultant on 7/3/25 at 10:02 a.m., she indicated that during an interview with Resident H, the resident indicated LPN 15 gave her pain medication early and she received two oxycodone tablets.

During an interview with Resident H, on 7/3/25 at 10:26 a.m., she was unable to recall being given medications early on 6/2/25 and 6/3/25.

2. Resident K's record was reviewed on 7/2/25 at 10:42 a.m. Diagnoses included spina bifida (spinal cord defect), bilateral above knee amputations, and chronic pain syndrome.

Physician orders included oxycodone-acetaminophen 5-325 mg give 1 tablet by mouth every 4 hours while awake.

The resident's eMAR indicated doses of oxycodone-acetaminophen scheduled for 6/3/25 at 12:00 a.m. was administered by QMA 2 at 3:21 a.m. due to "patient care", and he refused his scheduled 4:00 a.m. dose on 6/3/25.

The resident's narcotic sheet, provided by the Corporate Nurse Consultant on 7/2/25 at 10:36 a.m., indicated doses were signed out by LPN 15 on 6/2/25 at 8:00 p.m., 6/3/25 at 12:00 a.m. with

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the comment "not given" signed by LPN 16, and 6/3/25 at 4:00 a.m. with the comment "not given" signed by LPN 16 and 6/3/25 at 2:00 a.m. by QMA 2.

A medication card for comparison was not provided prior to exit.

3. Resident L's record was reviewed on 7/2/25 at 11:58 a.m. Diagnoses included COPD, peripheral vascular disease, and chronic pain syndrome.

Physician orders included oxycodone 5 mg give 5 mg by mouth every eight hours at 6:00 a.m., 2:00 p.m., and 10:00 p.m.

The resident's eMAR indicated doses of oxycodone scheduled on 6/2/25 at 10:00 p.m. were given on 6/3/25 at 4:00 a.m. and a dose scheduled 6/3/25 at 6:00 a.m. was given by LPN 16.

The resident's narcotic count sheet provided by the Corporate Nurse Consultant on 7/2/25 at 10:36 a.m. indicated a dose of oxycodone was signed out by LPN 16 on 6/3/25 at 1:00 a.m. and 6/3/25 at 6:00 a.m.

During an interview with LPN 16 on 7/3/25 at 9:43 a.m. she indicated a dose of oxycodone for resident L was due at 12:00 a.m. She took the medication out of the card and indicated QMA 19 gave the medication. She was unable to recall which medications she administered and which medications QMA 19 administered on 6/3/25. LPN 16 indicated it was not appropriate for someone to remove a medication from the card and another person administer the medication.

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4. Resident M's record was reviewed on 7/2/25 at 10:47 a.m. Diagnoses included COPD, opioid use, restless legs syndrome, other chronic pain, and radiculopathy (nerve pain) of the lumbar (lower back) region.

Physician orders included, oxycodone-acetaminophen 10-325 mg give 1 tablet every 4 hours as needed for pain.

The resident's eMAR indicated she was given doses of oxycodone-acetaminophen on 6/2/25 at 4:51 p.m. and 6/3/25 at 10:22 a.m.

The resident's narcotic count sheet provided by the corporate nurse consultant on 7/3/25 at 10:08 a.m., indicated doses of oxycodone-acetaminophen were signed out by LPN 15 on 6/2/25 at 10:00 p.m., 6/3/25 at 2:00 a.m., and 6/3/25 at 6:00 a.m.

A medication card for comparison was not provided prior to exit.

During an interview with the Corporate Nurse consultant on 7/3/25 at 10:53 a.m., she indicated no medication reconciliation was performed for resident M for the doses signed out on 6/2/25 at 10:00 p.m., 6/3/25 at 2:00 a.m., and 6/3/25 at 6:00 a.m.

An untitled facility document was provided by the Corporate Nurse Consultant on 7/3/25 at 11:05 a.m. indicated the following: "1. How many medications were ordered to be given?...2. All medications given AND documented immediately after administered?...6. Medications area given within at least 60 minutes before or after scheduled times?..." During a concurrent

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interview, she indicated the document was part of the orientation check off process and was given to all staff authorized to give medications.

A current facility policy provided by the Corporate Nurse Consultant on 7/2/25 at 12:08 p.m. and titled, "Controlled Medication", indicated the following: " ...2. At each shift change or when keys are rendered, a physical inventory of all controlled medication is conducted by two staff members who are either license nurses, medication technicians, or appropriate staff per state regulations and is documented on the controlled medications accountability record. This is completed as follows: a. The licensed nurse or medication technician surrendering the keys, along with the licensed nurse or medication technician assuming the keys will review the controlled medication accountability book for each resident's medication(s) for each resident in the narcotic drawer. The licensed nurse or medication technician surrendering the keys along with the licensed nurse or medication technician assuming the keys will ensure the count of the remaining medications (s) match the medication accountability book ....b. Any medication count discrepancies or medication card count discrepancies that can't be reconciled by the licensed nurse and/or medication technician need to be reported to the Director of Nursing (DON) immediately.

A current facility policy provided by the Corporate Nurse Consultant on 7/2/25 at 12:08 p.m. and titled, "Drug Diversion", included the following: " ...2. Any medications discrepancies that can't be reconciled by the licensed nurse and/or medication tech or for any suspected drug diversions of medications, need to be reported to

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the Director of Nursing (DON) immediately. 3. All suspected incident of drug diversions will be thoroughly investigated. 4. Any discrepancies that cannot be reconciled, will be reported to all appropriate government licensing, regulatory, and law enforcement agencies."

A current facility policy provided by the Corporate Nurse Consultant on 7/3/25 at 10:51 a.m. and titled, "Medication Administration General Guidelines", indicated the following: "Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices, ...4. Medications are to be administered at the time they are prepared. 5. The person who prepares the dose for administration is the person who administers the dose ....14. Medications are administered within 60 minutes of scheduled time ...Unless otherwise specified by the prescriber, routine medications are administered according to the established medication administration schedule for the nursing care center .... Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of any medications. 2. If a dose of regularly scheduled medication is withheld, refused, or given at other than the scheduled time (for example, the resident is not in the nursing care center at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered on the reverse side of the record provided for PRN documentation. 4. The resident's MAR/TAR is initialed by the person

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F 755	Continued From page 19 administering the medication, in the space provided under the date, and on the line for that specific medication dose administration and time. 5. When PRN medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral), and, if applicable, the injection site. b. Complaints or symptoms for which the medication was given. c. Results achieved from giving the dose and the time results were noted. d. Signature or initials of person recording administration or initials of person recording effects ...." This citation relates to Complaint IN00461866. 3.1-48(c)(2)	F 755		