STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155654	A. BUILDING 00 B. WING	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENGLEWOOD HEALTH & REHABILITATION CENTER	2237 ENGLE RD FORT WAYNE, IN 46809

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00415356, IN00415766 and IN00416564. This visit included a focused infection control survey. Complaint IN00415356 - No deficiencies related to the allegations are cited. Complaint IN00415766 - No deficiencies related to the allegations are cited. Complaint IN00416564 - Federal and State deficiencies related to the allegations are cited at F 602. Survey dates: September 5 and 6, 2023. Facility number: 000498 Provider number: 155654 AIM number: 100266110 Census Bed Type: SNF/NF: 51 Total: 51 Census Payor Type: Medicare: 1 Medicaid: 45 Other: 5 Total: 51 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed September 12, 2023	F 0000	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by Englewood Health and Rehabilitation Center. This plan of correction is prepared and executed because it is required by the provisions of State and Federal law. Englewood Health and Rehabilitation Center maintains that the alleged do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. As a consideration of the survey results the facility respectfully requests a paper review of the plan of correction.	
F 0602 SS=E	483.12 Free from Misappropriation/Exploitation			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Molly Linder	Administrator	09/22/2023

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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Bldg. 00	§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. During interview and record review the facility failed to ensure narcotic medications were handled securely for 4 of 4 residents reviewed. (Resident B, Resident C, Resident D and Resident E) Findings include: A review on 9/5/2023 at 12:10 P.M., of a facility's State Reported Incident provided by the Administrator in Training (AIT) on 9/5/2023 at 11:24 AM indicated on 8/30/2023 at 4:01 PM, an unnamed nurse reported the narcotic count sheet and the narcotic medication on hand did not match for Resident B. An investigation was initiated immediately, included interviews with nurses involved and reviewing the camera footage. The report indicated LPN (Licensed Practical Nurse) 1 was suspended pending the investigation. The facility's follow up report to the investigation, dated 8/31/2023, indicated LPN 1 admitted to placing a Percocet (a narcotic medication used for pain) in her pocket. She indicated she had signed out the Percocet thinking it was scheduled routinely instead of PRN (as needed). She indicated she planned to destroy the medication with the on-coming nurse, however she failed to destroy the medication. When questioned about the whereabouts of the medication, she indicated it had probably dissolved in her pocket when it went through the	F 0602	ol class="NumberListStyle1 SCXW150480287 BCX0" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Residents B, C, D and E were not negatively affected by the alleged deficient practice. Each one received their PRN narcotic pain medications which were effective to control their pain to their level of pain tolerance. p paraid="2089176927" paraeid="{c271dbb0-cc29-4326-84c1-3a560750f773}{32}" > 2. How be identified and what corrective action(s be taken?	10/22/2023

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	washing machine. The follow up report also indicated during the investigation it was discovered Resident C had a Medication Card of Ambien (a sedative-hypnotic, to help sleep) with 11 tablets on the card and a Controlled Substance Sign-out Sheet for Norco (a narcotic medication used for pain) indicated 11 tablets remained. However, there was no sign out sheet for the Ambien and no Norco to be counted. The follow-up report indicated the local Police department was contacted and a police report was filed. The facility's investigation included staff interviews on 8/30/23. RN (Registered Nurse) 2 indicated the narcotic count with the off going nurse was correct, but when she was giving medications to Resident C, she realized the narcotic count sheet for Ambien was missing and a pharmacy blister pack for the 11 Norco pills was also missing. RN 2 recounted all other narcotics and all the other medications were counted correctly. RN 2 indicated she notified the DON (Director of Nursing) and the Nurse Manager immediately. A written statement by LPN 1 indicated, on 8/29/23 she had double checked herself on the Narcotic count. She intended to waste one Percocet with oncoming nurse, but put it in her pocket and forgot about it. She indicated she had counted with the oncoming nurse and the count was correct. The statement was signed by LPN 1. 1. A review of Resident B's records began on 9/5/2023 at 2:00 P.M., indicated diagnosis included fibromyalgia, low back pain, atrial fibrillation, hypertension, and heart disease. Resident B's current MDS (Minimal Data Set)		Residents residing on our receiving opioid PRN pain medications had the potential to be affected by the deficient practice. ol class="NumberListStyle1 SCXW150480287 BCX0" role="list" start="3" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" 3. What measures will be put into place or what systemic changes will be made to ensure that deficient practice does not recur? LPN 1 was terminated 9/1/23 following investigative findings. Nurses educated on Preparing Controlled Substances for Administration policy to include documentation of each medication given. DON/designee to review packing slips daily following clinical meeting X4 weeks, then weekly X8, then monthly X3 to ensure PRN opioid narcotics received as well as the correct count sheets are present on each medication cart.	

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	Assessments dated 7/18/2023 indicated a BIMS (Brief Interview for Mental Status) score was 14, cognitively intact. The Pain Assessment Interview indicated Resident B had frequent pain and the pain limited their activity. Pain was rated an 08/10 but the resident only received opioid medication on 1 day of the 7 day assessment period. A review of Resident B's orders indicated an order with a start date on 7/19/2023 for Percocet 5-325 mg (milligram, a medication dose measurement) to give 1 tablet by mouth (po) every 4 hours as needed for pain. On 9/5/2023 at 4:00 P.M., the AIT and Nurse Manager provided copies of Resident B's MAR (Medication Administration Record) dated August 2023 and Resident B's Pharmacy sign-out sheets for the Oxycodone/APAP (Percocet) 5-325 mg tablets. These documents were compared with the AIT and Nurse Manager. The pharmacy sign-out sheet beginning on 8/10/23 indicated 30 tablets were received by the facility on 8/8/2023. Documentation indicated the following: On 8/10/23 at 4:45 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/10/2023 at 4:45 PM. On 8/10/23 at 9:00 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/10/2023 at 9:00 PM. On 8/11/2023 at 5:00 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/11/2023 at 5:00 PM. On 8/11/2023 at 9:00 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet		DON/designee to audit all opioid PRN narcotic count sheets daily during clinical meeting X 4 weeks, then weekly X8, then monthly X3 to ensure narcotic count sheets match documentation of administration on resident's MAR. p paraid="1632432937" paraeid="{c271dbb0-cc29-4326-84 c1-3a560750f773}{164}" > 4. How will the corrective action(s) be monitored to ensure the deficient practice will not recur? Audits/findings will be forwarded to QA monthly for review. The facility through the QAPI program, will review, update, and make changes to the POC as needed for sustaining compliance for no less than 6 months. Frequency and duration of the reviews will be adjusted as needed. After consecutive compliance is achieved, the DON and/or designee will randomly complete an audit to ascertain continued compliance annually. p paraid="858231463" paraeid="{c271dbb0-cc29-4326-84 c1-3a560750f773}{215}" >	

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	was administered on 8/11/2023 at 9:00 PM. On 8/15/2023 at 4:00 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/15/2023 at 4:00 PM. On 8/15/2023 at 8:00 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/15/2023 at 8:00 PM. On 8/17/2023 at 3:00 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/17/2023 at 3:00 PM. A new Pharmacy Controlled Substance Record for Resident B indicated 30 Percocet 5-325 mg tablets were received by the facility on 8/16/23 and indicated the following: On 8/17/2023 at 8:30 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/17/2023 at 8:30 PM. On 8/19/2023 at 5:00 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/19/2023 at 5:00 PM. On 8/19/2023 at 9:30 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/19/2023 at 9:30 PM. On 8/20/2023 at 4:00 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/20/2023 at 4:00 PM. On 8/20/2023 at 8:30 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/20/2023 at 8:30 PM. On 8/22/2023 at 3:15 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet		5. By what date will the systematic changes be completed? October 22, 2023	

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	was administered on 8/22/2023 at 3:15 PM. On 8/20/2023 at 4:00 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/20/2023 at 4:00 PM. On 8/24/2023 at 3:00, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/24/2023 at 3:00 PM. On 8/24/2023 at 8:30 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/24/2023 at 8:30 PM. A new Pharmacy Controlled Substance Record for Resident B indicated 30 Percocet 5-325 mg tablets were received by the facility on 8/24/2023 and indicated the following: On 8/28/2023 at 4:00 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/28/2023 at 4:00 PM. On 8/29/2023 at 4:00 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/29/2023 at 4:00 PM. On 8/29/2023 at 8:00 PM, 1 tablet was signed out on the narcotic sheet by LPN 1. The August MAR was lacking documentation the Percocet was administered on 8/29/2023 at 8:00 PM. On 9/6/2021 at 10:35 A.M., the AIT provided copies of Resident B's records labeled Pharmacy Controlled Substance Record for Percocet 5-325 mg. When compared the August 2023 MAR to the Pharmacy sign-out sheet, it indicated LPN 1 had signed out Percocet 5-325 mg tablets on 8/3/2023 at 5:05 PM and at 9:30 PM. The August MAR was lacking documentation the Percocet 5-325 mg tablets were administered on 8/29/2023 at 5:05 PM and at 9:30 PM.			

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	On 8/5/2023 LPN 1 had signed out Percocet 5-325 mg tablets on 8/5/2023 at 5:30 PM and at 9:30 PM. The August MAR was lacking documentation the Percocet 5-325 mg tablets were administered on 8/5/2023 at 5:30 PM and at 9:30 PM. On 8/6/2023 LPN 1 had signed out Percocet 5-325 mg tablets on 8/6/2023 at 3:30 PM and at 7:25 PM. The August MAR was lacking documentation the Percocet 5-325 mg tablets were administered on 8/6/2023 at 3:30 PM and at 7:25 PM. Review of the August 2023 MAR indicated LPN 1 had given evening shift medications on the following dates, 8/3/2023, 8/5/2023, 8/6/2023, 8/10/2023, 8/11/2023, 8/15/2023, 8/17/2023, 8/19/2023, 8/20/2023, 8/22/2023, 8/24/2023, 8/28/2023 and 8/29/2023. 2. A review of Resident C's records began on 9/5/2023 at 3:00 P.M., indicated diagnosis included medical complications of internal fixation device of bone of left lower leg, intervertebral disc degeneration, low back pain, venous insufficiency, heart disease and hypertension. The Admission MDS Assessment dated, 7/10/2023 indicated a BIMS Score of 13, cognitively intact. The Pain Assessment Interview indicated Resident C had frequent pain and was rated an 08/10. Resident C had major orthopedic surgery and had received opioid medication on 6 days of the 7 day assessment period. Resident C had orders for Zolpidem Titrate (Ambien) 10 mg tablet, give 1 tablet every 24 hours prn for sleep at bed time, started on 7/14/2023 and discontinued on 8/15/2023. A new order for Zolpidem 10 mg tablet, give 1 tablet every 24 hours as needed for trouble sleeping,			

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	started on 8/15/2023. The Zolpidem was discontinued when Resident C was discharged on 9/1/2023. The facility did not have a Pharmacy Controlled Substance sign-off record for the Zolpidem. Review of the August 2023 MAR indicated Resident C was administered Zolpidem 4 nights in August. Resident C had orders for Norco (Hydrocodone-Acetaminophen) 5-235 mg 1 tablet every 4 hours as needed for pain, start date 7/18/2023 and a discontinue date of 8/2/2023. A new order for Norco 7.5-325 mg 1 tablet every 4 hours as needed for pain with a start date of 8/2/2023. The Pharmacy Controlled Substance Sign-out sheets were missing for Norco 5-325 mg tablets administered 8/1/23 to 8/2/2023 and Norco 7.5-325 mg administered from 8/2/2023 to 8/16/2023. A Review of the Pharmacy Controlled Substance record for 30 tablets of Norco 5-325 mg had a received date of 8/16 written on the 1st line and indicated the following: On 8/17/2023 LPN 1 had signed out Norco 7.5-325 mg tablets on 8/17/2023 at 5:00 PM and at 9:00 PM. The August MAR was lacking documentation the Norco 5-325 mg tablets were administered on 8/17/2023 at 5:00 PM and at 9:00 PM. On 8/19/2023 LPN 1 had signed out 7.5-Norco 325 mg tablets on 8/19/2023 at 5:30 PM and at 9:30 PM. The August MAR was lacking documentation the Norco 5-325 mg tablets were administered on 8/19/2023 at 5:30 PM and at 9:30 PM.			

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	On 8/20/2023 LPN 1 had signed out Norco 7.5-325 mg tablets on 8/20/2023 at 4:00 PM and at 8:30 PM. The August MAR was lacking documentation the Norco 5-325 mg tablets were administered on 8/20/2023 at 4:00 PM and at 8:30 PM. On 8/22/2023 LPN 1 had signed out Norco 7.5-325 mg tablets on 8/22/2023 at 2:15 PM and at 9:00 PM. The August MAR was lacking documentation the Norco 7.5-325 mg tablets were administered on 8/22/2023 at 2:15 PM and at 9:00 PM. Review of the August 2023 MAR indicated LPN 1 had given evening shift medications on the following dates, 8/3/1012, 8/5/2023, 8/6/2023, 8/10/2023, 8/11/2023, 8/15/2023, 8/17/2023, 8/19/2023, 8/20/2023, 8/22/2023, 8/24/2023, 8/28/2023 and 8/29/2023. A review of Resident C's progress notes indicated there was no documentation for administration of the Norco nor the effectiveness of the medication for the pain. An interview with Nurse Manager 3, on 9/6/2023 at 10:00 A.M., indicated she had called the Pharmacy and was informed the Pharmacy had sent the facility 1 blister card with 40 tablets of Norco 5-325 mg on 7/14/2023, and 7 blister cards with 30 tablets each of Hydrocodone/APAP 7.5 mg on the following dates, 7/18/2023, 7/25/2023, 8/2/2023, 8/7/2023, 8/15/2023, 8/23/2023 and 8/29/2023. Nurse Manager 3 indicated they could only find 2 of the 8 Controlled Substance Sign-out records: 1 blister card received on 8/16/23 for 30 tablets and 1 blister card received on 8/30/2023 for Resident C. 3. A review of Resident D's records on 9/6/2023 at			

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	10:20 A.M., indicated diagnoses included , left thigh pain, contracture, stroke with hemiplegia/hemiparesis (weakness or paralysis on one side of the body), aphasia (loss ability to understand or express speech), dysphasia (difficulty swallowing), cognitive communication deficit, and hypertension. Review of the current Quarterly MDS Assessment indicated a BIMS score of 12, moderate cognitive impairment. A Pain Management assessment indicated the resident had pain rarely and rated it 04/10. Resident D received an opioid on 7 days of the 7 day of the assessment period. Resident D had an order for Hydrocodone-Acetaminophen 5-325 mg tablet, to give 1 tablet via Peg Tube (a type of feeding tube into the stomach) every 6 hours and had a start date of 3/5/2023. A review of the Pharmacy Controlled Substance Record for Resident D's Hydrocodone indicated the following when compared with the August 2023 MAR, indicated the Hydrocodone-Acetaminophen 5-325 was sign-out consistently at 12 A.M., 6 A.M., 12 P.M., and 6 P.M. The Pharmacy Controlled Substance Records were missing from 8/6/2023 to 8/19/2023. LPN 1 was the last nurse to sign off the Controlled Substance Record on 8/5/2023 at 6:00 P.M. On 8/29/2023 Resident D's MAR indicated the Hydrocodone-Acetaminophen 5-325 mg at 1800 (6:00 PM) was documented as administered by LPN 1, but was not signed out on the Controlled Substance Record. The sign out record was dated 8/29 and a line drawn through it. In an interview on 9/6/2023 at 11:40 A.M. Nurse Manager 3 indicated she had called the Pharmacy and was informed by the Pharmacy they had sent the facility the following quantities of			

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	Hydrocodone 5-325 mg tablets for Resident D. On 7/5/2023-56 tablets, 7/20/2023 - 60 tablets, 8/5/2023 - 60 tablets, 8/18/2023 - 60 tablets, 8/31/2023-60 tablets. She indicated the Controlled Substance Sheets were missing for the shipments on 8/5/2023 - 60 tablets. She also indicated LPN 1 had completed the last card prior to the missing sign-out sheet. 4. A review of Resident E's records on 9/6/2023 at 11:00 A.M., indicated diagnoses included chronic pain, insomnia, emphysema, epilepsy and anxiety. The most current Quarterly MDS Assessment, dated 8/31/2021 indicated Resident E's BIMS score was 10, moderate cognitive impairment. A Pain Management assessment indicated Resident E had pain occasionally, rated a 06/10, and had received opioid medications on 7 days of the 7 day assessment period. Resident E had an order for Hydrocodone-Acetaminophen 5-325 mg tablet, 1 tablet by mouth 3 times a day for pain, start date was 6/1/2023 and Discontinued on 8/4/2023. The Pharmacy Sign-out Sheet was received by the facility on 7/20/2023. It indicated LPN 1 administered the last tablet of the 45 tablets of Hydrocodone-Acetaminophen 5-325 mg on 8/3/2023. An order for Hydrocodone-Acetaminophen 5-325 mg tablet, 1 tablet by mouth 4 times a day for pain and was to be given routinely with a start date was 8/4/2023. The Hydrocodone-Acetaminophen 5-325 mg tablets were signed off consistently 4 times a day through 8/3/2023 at 8:00 PM when LPN 1 signed off the last tablet on the sign-out record.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155654	A. BUILDING 00 B. WING	09/06/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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The facility was missing the Pharmacy Controlled Substance Sign-out for Resident E from 8/4/2023 through 8/31/2023, until a delivery on 8/31/2023 of 75 tablets Hydrocodone/APAP 5-325 mg with 2 sign off sheets, 1 sheet for 15 tablets and the other sheet for 60 tablets. These were started on 9/1/2023.

On 9/6/2023 at 11:40 A.M., an interview with Nurse Manager 3 indicated she had called the Pharmacy and was informed the Pharmacy had sent the facility the following quantities of Hydrocodone 5-325 mg tablets. On 7/18/2023-45 tablets, 8/2/2023 - 42 tablets, 8/4/2023 - 60 tablets, 8/15/2023 - 60 tablets, 8/30/2023- 15 tablets and 60 tablets. She indicated the Controlled Substance Sheets were missing for the shipments on 8/2/2023 - 42 tablets, 8/4/2023 - 60 tablets and 8/15/2023 - 60 tablets. She also indicated LPN 1 had completed the last card prior to the missing sign-out sheets.

LPN 1's employee file indicated LPN 1 had signed a Job Description for Licensed Practical Nurse (LPN) on 8/31/2022. The job description indicated, " ...Providing medical record documentation in accordance with facility policy and procedures. Completing (24) hour reports, end of shift reports, shift narcotic counts and documenting the destruction of outdated/discontinued medication in the medication destruction record according to facility policy and procedure ...."

During an interview with the AIT and Unit Manager 4 on 9/5/2023 at 4:30 P.M., they indicated the investigation for the missing narcotic had only reviewed the residents, who were receiving PRN narcotics on the 200 Hall. The AIT indicated they reviewed the camera footage and LPN 1 was observed to put something in her pocket. LPN 1

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	was suspended pending the investigation. Unit Manager 4 indicated they had not compared the Pharmacy Controlled Substance Sign-out records with the residents' MARS. LPN 1 admitted she had put the narcotic in her pocket and forgot to destroy it before leaving the facility. They indicated a report to the police and to the State Nursing Board was completed. They indicated they were not aware there were narcotics signed out by LPN 1 and not documented on the Resident's MARS. A current facility policy provided by the AIT on 9/5/2023 at 2:45 P.M., titled, Controlled Substances, revised on 7/2021, indicated, " ...It is the policy of this facility to store, administer, verify and destroy controlled substances in accordance with Federal, State and Local laws ...documentation of a correct count will be maintained for each controlled substance ...The facility will be maintaining a count record for the count sheets contained in the count book ...Verify the order by checking the Medication Administration Record (MAR) ...Obtain the controlled substance count sheet and verify the count is correct ...Read label again and prepare the medication for administration according to the procedure for administration by route. Record the amount removed of the controlled substance on the count record and put the correct number of remaining doses on the record ...Stay with the resident until the medication is swallowed if dose is orally administered ...When a new medication is added to the controlled substance box, a new sheet will be added to the count book ...When a medication is remove from the lock box for any reason, the count record will be removed for that drug ...The destruction of controlled substances will be performed with 2 licensed nurses at a minimum ...Controlled substances will be disposed			

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	of in accordance with Local, State, and Federal laws ...." A facility in-service on 8/30/2023 related to Narcotic Counts, indicated, " ...BOTH nurses are to count together at the medication cart. One reviewing the medication cards and the other the narcotic sheets. Nurse reading off the medication cards should read the resident's name, and name of the medication for each item to be counted. Document that count is completed on the narcotic count sheet. Should the count be off or a discrepancy noted, no one leaves until search is completed of medication carts, MARs reviewed for missing entries and Nurse Manager notification to receive further instructions ..." A current facility policy, used for the In-service of nurses on 8/30/2023. The policy was provided by the AIT on 9/5/2023 at 2:45 P.M., titled Counting Controlled Substances and responding to Errors in a Controlled Substance Count, indicated, " ...If the count and sign-out log still disagree, check the sign-out entries to detect a prior error in recording or count ...Check the resident's medication records and nurse's noted for doses that might have been given and not recorded ...." This Federal tag relates to Complaint IN00416564. 3.1-28(a)			