STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 00 B. WING	01/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALBANY HEALTH CARE & REHABILITATION CENTER	910 W WALNUT ST ALBANY, IN 47320

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00424167 and IN00425811. Complaint IN00424167 - No deficiencies related to the allegations are cited. Complaint IN00425811 - No deficiencies related to the allegations are cited. Survey dates: January 16, 17, 18, 19, and 22, 2024. Facility number: 000309 Provider number: 155432 AIM number: 100288960 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 12 Medicaid: 49 Other: 14 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed January 30, 2024.	F 0000	The completion of this plan of correction does not constitute an admission that the alleged deficiency exists. The plan of correction is provided as evidence of the facilities desire to comply with the regulations and continue to provide quality care in a safe environment. The facility is requesting a desk review for compliance.	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Gimre	Administrator	02/09/2024

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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	resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days.			

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	§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the			

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	facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).			
	Based on record review and interview, the facility failed to notify the Long-Term Care Ombudsman of transfers out of the facility for 2 of 3 residents reviewed for hospitalizations (Residents 37 and 66). Findings include: 1. Resident 37's clinical record was reviewed on 1/18/24 at 9:44 a.m. A nurses note, dated 12/25/23 at 9:56 a.m., indicated the resident was sent to the hospital for altered level of consciousness. A nurses note, dated 12/26/23 at 2:50 p.m., indicated the resident had been admitted to the hospital with altered mental status and lethargy. A nurses note, dated 12/28/23 at 1:05 p.m., indicated the resident returned from the hospital. The facility ombudsman notification binder, provided by the Social Services Designee (SSD)	F 0623	1. Records of transfer/discharges reviewed of those residents to ensure Ombudsman is notified of previous transfer/discharges 2. All records of transfer/discharges reviewed of all current resident to ensure Ombudsman is notified of previous transfer/discharge 3. The policy related to Ombudsman notification was reviewed and no changes were indicated. Social Service Director educated on regulation of notification of ombudsman for all transfer/discharges. Audit to be completed by Social Service Director/designee to perform routine audit to ensure accuracy of ombudsman notification. 4. Service Director/designee will	02/09/2024

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	on 1/22/24 at 11:28 a.m., lacked ombudsman notification for the resident's transfer to the hospital. 2. Resident 66's clinical record was reviewed on 1/18/24 at 3:24 p.m. A nurses note, dated 12/15/23 at 1:10 p.m., indicated the resident was sent to the hospital for altered level of consciousness, hallucinations, and to prevent self-harm. A nurses note, dated 12/16/23 at 4:45 p.m., indicated the resident was admitted to the hospital for altered mental status. A nurses note, dated 12/19/23 at 5:05 p.m., indicated the resident returned from the hospital. The facility ombudsman notification binder, provided by the Social Services Designee (SSD) on 1/22/24 at 11:28 a.m., lacked ombudsman notification for the resident's transfer to the hospital. During an interview, on 1/22/24 at 3:42 p.m., the SSD indicated the ombudsman had not been notified of Resident 37's and Resident 66's transfers to the hospital. The residents had been placed on hospital leave. The electronic medical record report she utilized to notify the ombudsman did not include the residents on hospital leave. A facility policy, provided by the Nurse Consultant on 1/22/24 at 4:22 p.m., titled "Admission, Transfer, Discharge Policy" and dated 10/31/22, indicated " ...Emergency Transfer to Acute Care ...A copy of the notification given/sent to the resident and/or resident		perform an audit which will include completion of ombudsman notification, signature, and date from designee for notification of the ombudsman. Audits will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum 6 months. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. 5. February 9th 2024	

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	representative should also be sent to the ombudsman as required, and the facility must maintain evidence that the notice was sent. ..." 3.1-12(a)(6)(A)(iv)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.			
	Based on observation, interview, and record review, the facility failed to implement care plan interventions to prevent falls for 1 of 5 residents reviewed for falls (Resident 22). Finding includes: During an observation, on 1/16/23 at 11:46 a.m., Resident 22 ambulated with a rolling walker in the hallway. She was bent over at the waist and pushed the walker in front of her. Another resident had her hand on Resident 22's hip area and encouraged Resident 22 to walk to the dining area. During an observation, on 1/18/24 at 10:28 a.m., the resident ambulated in her room using the footboard of the bed to steady herself. During an observation, on 1/22/24 at 9:40 a.m., the resident ambulated with the rolling walker in the hall wearing purple foam clogs.	F 0689	1. Fall care plan was reviewed for Resident 22 and revised to accurately reflect the current interventions that are being utilized. All interventions currently implemented are appropriate and effective. 2. All residents at risk for falls have the potential to be affected. Fall care plans for all those residents were reviewed to ensure that all care planned interventions were implemented and remain effective. Revisions were made as indicated. 3. The Fall Investigation and Risk Evaluation policy was reviewed and no changes were indicated. Nursing staff will be educated on this policy.	02/09/2024

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	Resident 22's clinical record was reviewed on 1/18/24 at 3:23 p.m. Diagnoses included dystonia, vascular dementia, anxiety, heart failure, unspecified, low back pain, muscle weakness (generalized), abnormalities of gait and mobility, pain in right knee, delusional disorders, and major depressive disorder, recurrent, severe with psychotic symptoms. Current physician orders included divalproex sodium 125 mg (for mood stabilization) every evening, donepezil 10 mg (for dementia) at bedtime, clonazepam (for dystonia - movement disorder that causes muscles to contract involuntarily) 2 mg two times a day, quetiapine 25 mg (antipsychotic for delusional disorder) two times a day, and hydrocodone-acetaminophen 10-325 mg (opioid for pain) every six hours. An 11/20/23 annual Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. She required substantial/maximal assistance with bed-to-chair/chair-to-bed transfers, toilet transfers, and tub/shower transfers. She was frequently incontinent of bladder and bowel. A current care plan for falls related to confusion and weakness (7/3/23) included the following interventions: I will be provided non-slip socks instead of foam clogs until my family can provide proper fitting shoes (1/5/24) and silent alarms when in bed and/or chair (11/16/23). Quarterly fall risk assessments completed on 10/4/23 and 1/4/24 indicated the resident was a high fall risk. A nurses note, on 10/28/23 at 12:45 a.m., indicated		4. DON/designee will perform an audit including tracking each new fall intervention, revisiting on day 2 and again on day 14 to ensure it was care-planned, implemented, and continues to be the most effective intervention. Audits will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum 6 months. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. 5. February 9th 2024	

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	the resident had a witnessed fall. She was in the lounge when she backed out of the corner with her walker. Her walker got caught on the corner of the end table. She fell back into the door and hit her head. A small bump was noted to the back of her head. She stated her bottom hurt. A fall interdisciplinary team (IDT) note, on 10/31/23 at 10:45 a.m., indicated the 10/28/23 fall was reviewed. The initial intervention was to redirect or assist the resident when wandering in the late-night hours. The IDT agreed the lounge door was to be closed during sleep hours to provide safety to residents who may be wandering in late hours. A nurses note, on 11/10/23 at 3:10 p.m., indicated the resident was found on the floor in another resident's room. The resident attempted to lie down in the bed by the window. The bed moved. The resident fell to the floor. The resident was found sitting on her buttocks with her legs and feet out in front of her. Bruising was noted to her left upper arm. An immediate intervention was to ensure all the beds were locked. A fall IDT note, on 11/13/23 at 12:58 p.m., indicated the fall on 11/10/23 was reviewed. Staff was to ensure all the beds on the special unit were locked while stationary. A nurses note, on 11/16/23 at 5:31 a.m., indicated the resident sat on the floor in the hall with her shoes on. She leaned on the wall with her walker in front of her. No injuries were identified. An immediate intervention was to have a bed alarm placed until the resident was evaluated by the IDT. A fall IDT note, on 11/16/23 at 3:41 p.m., indicated			

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the fall on 11/16/23 was reviewed. The resident was unable to state what had happened during her fall. She had labs drawn and a urinalysis with a culture and sensitivity completed.

A nurses note on 12/8/23 at 11:09 p.m., indicated the resident ambulated with her rolling walker down the hall and fell backwards onto her buttocks. No injuries were identified. An immediate intervention was to offer the resident a snack at 10:00 a.m.

A fall IDT note, on 12/11/23 at 10:13 p.m., indicated the fall on 12/8/23 was reviewed. The resident stated she wanted some crackers after her fall. The resident's falls on 11/10/23 and 11/15/23 were reviewed for a pattern. An intervention for the resident to receive a snack at 10:00 a.m. was added.

A nurses note, on 1/5/24 at 2:40 p.m., indicated the resident was found in her room next to her bed with her walker in reach. The resident stated she was going to the dining room.

A nurses note, on 1/5/24 at 5:33 p.m., indicated the immediate intervention for the fall was to provide the resident with non-slip socks instead of her foam clogs until the family could provide proper fitting shoes.

A fall IDT note, on 1/8/24 at 2:11 p.m., indicated the fall on 1/5/23 was reviewed. The resident received a skin tear to her right elbow. An intervention for the staff to offer the resident a snack when she appeared restless was added.

The resident's Bedside Kardex Report, provided by the Nurse Consultant on 1/19/24 at 3:19 p.m., indicated the resident was to be provided with

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	non-slip sock instead of foam clogs until the family could provide proper fitting shoes. Silent alarms to be used when in bed and/or chair. During an interview, on 1/22/24 at 10:49 a.m., CNA 9 indicated she did not usually work on the secured unit. She utilized the Kardex to tell her what interventions were required for falls and behaviors. During an interview, on 1/22/24 at 10:58 a.m., CNA 10 indicated the resident usually wore her foam clogs and walked well in them. The resident did not walk well in nonslip socks. Silent alarms were not used for the resident. During an interview, on 1/22/24 at 11:04 a.m., the Dementia Care Director indicated the use of the nonskid socks was up to the family whether they wanted the resident to wear them or not. The resident did not have silent alarms utilized for her bed or chair. Interventions for falls were listed in the Kardex. During an interview, on 1/22/24 at 11:48 p.m., LPN 4 indicated she believed the resident was permitted to wear foam clogs until the family found a new pair of better fitting shoes. Silent alarms for the bed and chair were not used for the resident. During an interview, on 1/22/24 at 12:00 p.m., the DON indicated she was uncertain about the intervention for non-slip sock instead of foam clogs for the resident. According to the care plan, the resident should have been wearing nonskid socks and should have silent alarms. The ADON managed the resident falls and may have more information.			

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	During an interview, on 1/22/24 at 12:23 p.m., the ADON indicated the interventions added to the care plan were probably added by a nurse as an immediate intervention after a fall. She was unaware of the resident's intervention to have a silent alarm or to wear non-slip socks instead of foam clogs. A facility policy, dated 11/1/23, provided by the DON at 1/22/24 at 12:19 p.m., titled "Fall Prevention Program," indicated " ...Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care. a. Interventions will be monitored for effectiveness. b. The plan of care will be revised as needed ...." 3.1-45(a)(2)			
F 0728 SS=D Bldg. 00	483.35(d)(1)-(3) Facility Hiring and Use of Nurse Aide §483.35(d) Requirement for facility hiring and use of nurse aides- §483.35(d)(1) General rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless- (i) That individual is competent to provide nursing and nursing related services; and (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §483.151 through §483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). §483.35(d)(2) Non-permanent employees. A facility must not use on a temporary, per			

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	diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. §483.35(d)(3) Minimum Competency A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual- (i) Is a full-time employee in a State-approved training and competency evaluation program; (ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b).			
	Based on interview, and record review, the facility failed to remove CNA students from CNA duties when they failed to become certified within four months of their hire date (CNA Student 5 and 6). Finding includes: Review of employee records on 1/19/23 at 2:49 p.m. indicated CNA Student 5 and CNA Student 6 were hired on 8/9/23. Review of the nursing employee schedules from 12/10/23 through 1/15/23, provided by the Nurse Consultant on 1/19/23 at 4:10 p.m., indicated the following: CNA 5 had worked on 12/11/23, 12/13/23, 12/14/23, 12/15/23, 12/18/23, 12/19/23, 12/20/23, 12/22/23, 12/24/23, 12/27/23, 12/28/23, 1/3/24, 1/5/24, 1/7/24, 1/8/24, 1/10/24, 1/11/24, 1/12/24, 1/14/24, and 1/15/24.	F 0728	1. No residents were affected by the deficient practice. 2. All records of CNA training employees were reviewed to ensure compliance with regulations for hiring and use of nurse aides. 3. The policy related to Facility Hiring and Use of Nurse Aide was reviewed, and no changes were indicated. HR director educated on regulation for training nurse aides. Audit to be completed per HR director/designee to perform routine audit to ensure accuracy of CNA training program. 4. HR director/designee will perform an audit which will include	02/09/2024

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(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
	CNA 6 worked on 12/11/23, 12/12/23, 12/26/23, 12/30/23, 12/31/23, 1/1/24, 1/3/24, 1/5/24, 1/8/24, 1/13/24, and 1/14/23. During an interview on 1/22/24 at 12:00 p.m., the DON indicated CNA 5 had not yet passed her test. She was uncertain of the status of CNA 6. She was unaware the students had been hired more than 4 months ago. During an interview on 1/22/24 at 12:03 p.m., the Administrator indicated he was uncertain about the status of CNA 5 and CNA 6. He needed to contact the corporate person who managed the CNA students. During an interview on 1/22/24 at 12:20 p.m., the Administrator indicated CNA 5 and CNA 6 were both past the 120 days from their hire dates. He planned to immediately terminate, then rehire the students. A facility policy, revised 2/19/20, provided by the Nurse Consultant on 1/22/24 at 4:22 p.m., titled "Certified Nursing Assistant (CNA)," indicated " ...Must possess specific educational and experience requirements such as ...Certified by the State as a C.N.A. in good standing. (CNAs transferring from another state or graduating CNA students not yet certified, may work for 120 days while awaiting their certification.)...." 3.1-14(b)		completion of chart review, signature, and date from designee. Audits will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum 6 months. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. 5. February 9th 2024	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155432	A. BUILDING 00 B. WING	01/22/2024

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	emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). 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 order and that an account of all controlled drugs is maintained and periodically reconciled.			
	Based upon observation, record review, and interview, the facility failed to ensure accurate records were kept of the administration of controlled medications for 6 of 14 residents reviewed (Residents 22, 47, 56, 58, 66, and 67). Findings include: During an observation of the secured unit	F 0755	1. All records of controlled substances were reviewed for accuracy of count, shift to shift signatures, and all narcotics signed off as administered. 2. All residents receiving controlled substances have the potential to be affected. Controlled	02/09/2024

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	medication cart, accompanied by LPN 4, on 1/22/24 at 9:46 a.m., the narcotic reconciliation log was reviewed. A reconciliation of controlled medications was performed at this time by LPN 4, with the following concerns observed: Resident 56 had 23 tablets of hydrocodone (a narcotic pain medication) 5-325 tablets. The medication log indicated 24 tablets. Resident 56 had 28 tablets of alprazolam 0.25 mg (anxiolytic). The medication log indicated 29 tablets. Resident 58 had 18 tablets of hydrocodone-acetaminophen 5-325 mg tablets. The medication log indicated 19 tablets. Resident 67 had 27 tablets of pregabalin (anticonvulsant) 100 mg tablets. The medication log indicated 28 tablets. Resident 47 had 26 tablets of diphenoxylate (used to treat diarrhea). The medication log indicated 27 tablets. Resident 66 had 24 tablets of lacosamide (anticonvulsant) 100 mg. The medication log indicated 25 tablets. Resident 22 had 11 tablets of hydrocodone-acetaminophen 10-325 mg. The medication log indicated 12 tablets. Resident 22 had 14 tablets of clonazepam (benzodiazepine) 1 mg. The medication log indicated 16 tablets. During an interview with LPN 4, on 1/22/24 at 9:50 a.m., she indicated she did not sign out the		substance records for every assignment in facility were reviewed and are current without any inaccuracies or omitted entries. 3. The policy related to Controlled Substances was reviewed and no changes were indicated. Nursing staff educated to ensure that controlled substance records are accurately and immediately documented per facility policy. Audit to be completed per DON/designee to perform routine as well as random rounding to ensure accuracy of controlled substance records. 4. DON/designee will perform an audit which will include completion of controlled substance shift to shift count, signature of said count, and monitoring that controlled substances are documented immediately upon administration. Audits will be completed daily for 4 weeks, 2 times weekly for 8 weeks, monthly for 3 months, then quarterly for a minimum 6 months. The findings of these audits will be presented during the facility's monthly QAPI meetings and the plan of action adjusted accordingly. 5. February 9th 2024	

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	medications prior to administering them. Her practice was to document on the controlled medication logs at the end of the day. During an interview with the Director of Nursing, on 1/22/24 at 9:59 a.m., she indicated the controlled medications should have been logged off after each administration. Review of a current facility policy titled "Preparing Controlled Substances for Administration", dated 5/17, and provided by the DON on 1/22/24 at 10:28 a.m., indicated the following: "...General Guidelines: 1) Schedule I, II, III, and IV medications must be counted at the beginning and the end of each shift. 2) The count is normally conducted with one 'off-going' staff member and one 'on-coming' staff member...3) These medications must be signed out for each administration with the amount remaining accurately documented...15) Obtain the controlled substance sign out log. 16) Compare the amount in the container with the amount listed on the sign-out log. If incorrect, notify the charge nurse, unit manager, or director of nursing. If correct, proceed...19) Record the amount of medication removed on the sign-out log...." 3.1-25(e)(2)(3)			