STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145234	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl Pointe Nursing Rehab & Care	900 South Kiwanis Drive Freeport, IL 61032

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Observation, Interview, and Record Review the facility failed to prevent the misappropriation of resident's narcotic medication for three of three residents (R1, R2 & R3) reviewed for misappropriation of resident's property in the sample of four. The findings include:1. The Controlled Drug Receipt/Record/Disposition form dated 11/25/25 for R1 showed it was for Oxycodone 5 MG dose, 30 tablets, take 1 tablet by mouth daily as needed for pain. The form showed on 12/12/24 he had 4 tablets left. On 12/13/25 there were 2 tablets left with no documentation between the two dates to show administration. There was a note written on the sheet on 12/13/25 saying DON (Director of Nursing) aware and it was initialed by V7 Licensed Practical Nurse – LPN and V8 Registered Nurse – RN. On 2/11/26 V7 LPN stated in December 2025 there was an incident where she was coming in and switching with the night nurse, V10 LPN and the count for R1's Oxycodone was off. On the sheet there were 4 marked as being left and then they counted the medication and there were only two left instead of 4. The count went to 2 without showing where 2 pills went. V7 stated V10 couldn't come up with a reason as to why it was like that or where the pills went. V7 stated V10 then said she must have given him two pills which did not make sense. V7 stated she worked on 2/6/26 and R1 did not have Oxycodone. V7 stated the nurse before her documented a 9 on the MAR which meant R1 did not get the medication. V7 stated she thought R1 had run out of medication, so she went to the medication dispensing machine to get a dose of the medication. V7 stated the machine will prompt you to get a code from pharmacy. V7 stated she called the pharmacy and was asked if his Oxycodone order had changed. They went over his medication order and it wasn't changed and was the same as what was on file at the pharmacy. The pharmacist told her that R1 should have 16-20 pills left. V7 stated her access was denied by pharmacy until management was notified. V7 stated she notified the Director of Nursing. V5 - [NAME] President of Operations was contacted and she called pharmacy, and they told her on 1/17/26 there were two Oxycodone cards sent with 30 pills in each card, so they sent 60 pills. The February 2025 Medication Administration Record - MAR for R1 was reviewed and showed on 2/1, 2/3, 2/4 and 2/5 he did not receive Oxycodone 5 MG by mouth twice a day. The MAR showed on 2/2 that V8 RN signed off that she gave the medication in the morning and V10 LPN gave the medication at bedtime however the medication was not available. On 2/10/26 at 3:00 PM, R1's February 2025 MAR was reviewed with V8, and she stated she signed out his Oxycodone as given on 2/2/26 in error. It was not given; he did not have any available. On 2/10/26 at 1:14 PM, V5 [NAME] President of Operations stated last Friday (2/6/26) she was notified that R1 was missing oxycodone, so she started an investigation. V5 stated the missing oxycodone (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would be considered misappropriation of resident property. On 2/11/26 at 7:32 AM, R1 was in his room in bed on his back with head of bed elevated. R1 had all 4 extremities amputated. R1 had a tray table in front of him with personal items on it. R1 stated he was without his pain medication for 4 days and was told that they couldn't get it from the pharmacy. R2 stated he was in a lot of pain. He stated his pain was a 10/10 on the pain scale. R1 stated his amputation sites (all 4 extremities) felt like they were on fire. R1 stated he was given Tylenol, but he was still very uncomfortable, and it was very unpleasant. R1 stated he has chronic pain but when the shooting pains start and he feels like he is on fire that is the worst. R1 stated he watches to see that the nurses give him his pain medication. On 2/11/26 at 9:48 AM, V5 stated on 1/16/26 R1 had 2 cards of Oxycodone delivered and each card contained 30 tablets. V5 stated they are missing one of the Oxycodone cards. The Face Sheet dated 2/10/26 for R1 showed diagnoses including chronic obstructive pulmonary disease, major depressive disorder, alcohol abuse, hypertension, hyperlipidemia, hypothermia, superficial frostbite, traumatic ischemia of muscle, homelessness, nicotine dependence, lower leg partial traumatic amputation below knee, reduced mobility, acute post hemorrhagic anemia, hypokalemia, disorders of phosphorus metabolism, type 2 diabetes mellitus, acute respiratory failure with hypoxia, mild protein calorie malnutrition, and traumatic amputation. The facility's Abuse Prevention Program Facility Policy and Procedure (10/2023) showed abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. The policy did not show the definition of misappropriation of resident property. 2. The January 2026 MAR for R2 showed on 1/1 at 7:37 AM, 1/3 at 6:58 AM, 1/4 at 11:53 PM and 1/13 at 7:15 AM he was given hydromorphone 4 MG by either V8 RN or V10 LPN. There wasn't a Controlled Drug Receipt/Record/Disposition Form for R2 for the administration and reconciliation of the hydromorphone 4 MG given in January 2026. The Proof of Delivery List Report (pharmacy manifest) for R2's controlled medication showed on 12/3/25 there were two cards (card 1 and 2) of hydromorphone 4mg of 30 tabs in each card were delivered. The Controlled Drug Receipt/Record/Disposition Form (narcotic count sheet) was missing for card 1. On 2/11/26 at 7:40 AM, R2 was in his room sitting up in bed and watching TV. R2 stated he tries to stay away for the oral narcotic pain medication because he doesn't like how it makes him feel. R2 stated he used to take the hydromorphone, but he stopped taking that in December 2025. R2 stated he takes Tylenol if he has more pain than usual. R2 stated he takes gabapentin, has a fentanyl patch, and lidocaine patch. R2 stated he has Ultram but doesn't use that either. On 2/11/26 at 9:48 AM, V5 [NAME] President of Operations stated she was not aware of any medication problems for R2. V5 reviewed the January 2026 MAR for R2 and confirmed V8 and V10 were the only nurses that gave R2 the hydromorphone. On 2/12/26 at 3:45 PM, R2 confirmed again that he did not receive Hydromorphone doses in January (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2026. The Minimum Data Set, dated [DATE] for R2 showed he is alert, oriented, and cognitively intact. The Face Sheet dated 2/12/26 for R2 showed diagnoses including pathological fracture in neoplastic disease, tortuous aortic arch, acute kidney failure, degenerative disc disease, anemia, nicotine dependence, interstitial pulmonary disease, multiple myeloma, respiratory bronchiolitis interstitial lung disease, calculus of gallbladder, calculus of bile duct, sepsis, paroxysmal a fib, encounter for palliative care, anemia in chronic kidney disease, cardiomegaly, and morbid obesity. 3. R3's face sheet shows she was admitted to the facility on [DATE] with multiple diagnoses including pressure ulcer of sacral region, stage 4. R3's December 2025 MAR shows an order for Morphine Sulfate ER Extended Release 1 tablet by mouth twice daily for severe pain. The order was discontinued on 12/10/25. A new order for Morphine Sulfate ER 30 mg tablet three times a day was started on 12/30/25. R3's controlled drug receipt/record/disposition form for Morphine sulfate tablets 15 mg ER documents 30 tablets were dispensed on 11/16/25. The record shows on 12/31/25 at 9:00 AM, V8 signed out 2 tablets noting in parenthesis R3's order increased from 15 mg to 30 mg and marked error-not given. The entire line on the record is crossed off, leaving the count at 20. The next line shows V8 signing 1 tablet out for the same day, with an earlier time of 7:00 AM. The card was destroyed with 19 tablets. R3's Morphine Sulfate ER 30 mg tablet-controlled drug sheet shows on 12/31/25, V8 also signed out 1 tablet at 9:00 AM. On 2/13/26 at 3:00 PM, V5 said controlled medications should not be signed out after they have been discontinued. R3's manifest list of controlled medications, shows on 11/7/25, Hydrocodone/APAP 5-325 mg tablets, Rx number 11358133/001 and 002, each card with 30 tablets, 60 tablets in total. The controlled drug receipt record forms were requested, and the facility could not provide any documentation of receipt or destruction of the 60 tablets.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to notify the Illinois Department of Public Health and local law enforcement immediately of misappropriation of resident property for 1 of 4 residents (R1) reviewed for misappropriation of resident property in the sample of four.The findings include:The facility's Initial Report to Illinois Department of Public Health (IDPH) Regional office was dated 2/10/26 and showed the facility noted a discrepancy in residents' hydrocodone (narcotic medication) on 2/6/26; investigation initiated.The facility's Investigation: Unaccounted for Controlled Medication 2/6/26 showed V1 Administrator was notified on 2/2/26 that R1's oxycodone could not be refilled by pharmacy because it would be refilled too soon. V1 began an investigation for a potentially missing card of oxycodone. V1 did not locate the card. On 2/10/26 IDPH began an investigation into controlled drug diversion. The local law enforcement was notified on 2/10/26.On 2/10/26 at 1:14 PM, V5 [NAME] President of Operations stated last Friday (2/6/26) she was notified that R1 was missing oxycodone, so she started an investigation. V5 stated the missing oxycodone would be considered misappropriation of resident property. V5 stated it was not reported to IDPH and should have been. V5 stated the police were not notified and should have been.On 2/11/26 at 9:48 AM, V5 stated that she has discovered that there is an entire card (30 pills) of Oxycodone 5 MG tablets for R1.On 2/17/26 at 11:45 AM, V1 Administrator stated they are to immediately report theft to IDPH and the police.The facility's Abuse Prevention Program Facility Policy and Procedure (10/2023) showed .Informing local law enforcement. The facility shall also contact local law enforcement authorities (i.e., telephone 911 where available or the non-emergency number) in the following situations: When there is reasonable suspicion that a crime has been committed in a facility by a person other than a resident.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide effective pain management to a resident with phantom pain in all 4 amputated extremities. This failure resulted in R1 having severe pain from 1/31/26 to 2/6/26 when he missed 11 doses of medication. This applies to 1 of 3 residents (R1) reviewed for pain management in the sample of four.The findings include:On 2/11/26 at 7:32 AM, R1 was in his room in bed on his back with head of his bed elevated. R1 had all 4 extremities amputated. R1 had a tray table in front of him with personal items on it. R1 stated he was without his pain medication for 4 days and was told that they couldn't get it from the pharmacy. R2 stated he was in a lot of pain. He stated his pain was a 10/10 on the pain scale. R1 stated his amputation sites (all 4 extremities) felt like they were on fire. R1 stated he was given Tylenol, but he was still very uncomfortable, and it was very unpleasant. R1 stated he has chronic pain but when the shooting pains start and he feels like he is on fire that is the worst. R1 stated he watches to see that the nurses give him his pain medication.The Medication Administration Record dated January 2026, and February 2026 showed the last dose of his Oxycodone 5 MG that was to be given twice a day was at bedtime on 1/31/26. The next dose he received was on 2/6/26. R1 missed 11 doses of pain medication.The February 2025 Medication Administration Record - MAR for R1 was reviewed and showed on 2/1, 2/3, 2/4 and 2/5 he did not receive Oxycodone 5 MG by mouth twice a day. The MAR showed on 2/2 that V8 RN (Registered Nurse) signed off that she gave the medication in the morning and V10 LPN (Licensed Practical Nurse) gave the medication at bedtime however the medication was not available.On 2/10/26 at 3:00 PM, R1's February 2025 MAR was reviewed with V8, and she stated she signed out his Oxycodone as given on 2/2/26 in error. It was not given; he did not have any available.On 2/11/26 V7 LPN stated she worked on 2/6/26 and R1 did not have Oxycodone. V7 stated the nurse before her documented a 9 on the MAR which meant R1 did not get the medication. V7 stated she thought R1 had run out of medication, so she went to the medication dispensing machine to get a dose of the medication. V7 stated the machine will prompt you to get a code from pharmacy. V7 stated she called the pharmacy and was asked if his Oxycodone order had changed. They went over his medication order and it wasn't changed and was the same as what was on file at the pharmacy. The pharmacist told her that R1 should have 16-20 pills left. V7 stated her access was denied by pharmacy until management was notified. V7 stated she notified the Director of Nursing. V5 - [NAME] President of Operations was contacted and she called pharmacy, and they told her on 1/17/26 there were two Oxycodone cards sent with 30 pills in each card, so they sent 60 pills.On 2/11/26 at 9:48 AM, V5 stated on 1/16/26 R1 had 2 cards of Oxycodone delivered and each card contained 30 tablets. V5 stated they are missing one of the Oxycodone cards. On 2/17/26 at 11:56 AM, V3 Director of Nursing - DON stated they use a numeric pain scale in the facility for residents that can rate their pain. The scale is from 0-10 with zero being no pain and 10 severe pain/crying etc. It is the worst pain on the scale. V3 stated for residents that cannot give a number they look at nonverbal s/s (signs and symptoms) such as facial grimaces, moaning, squinting etc. V3 stated it was a concern for R1 to receive his medication as ordered to manage his pain. V3 stated they don't want R1's pain to become out of control because it can affect his quality of life.On 2/17/26 at 1:01 PM, V17 Nurse Practitioner - NP stated R1 has phantom pain, neuropathy, and back pain and that is why he has pain medication. It is important for him to have the medication and to receive it as ordered because it can lead to other medical problems and can affect his quality of life. R1's Minimum Data Set - MDS dated [DATE] showed no impairment of memory and he is cognitively intact.The Care Plan dated 1/14/26 for R1 showed resident is at increased risk for alteration in pain/discomfort. Resident has scheduled (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	and as needed medications ordered. Administer medications as ordered.The Face Sheet dated 2/10/26 for R1 showed diagnoses including chronic obstructive pulmonary disease, major depressive disorder, alcohol abuse, hypertension, hyperlipidemia, hypothermia, superficial frostbite, traumatic ischemia of muscle, homelessness, nicotine dependence, lower leg partial traumatic amputation below knee, reduced mobility, acute post hemorrhagic anemia, hypokalemia, disorders of phosphorus metabolism, type 2 diabetes mellitus, acute respiratory failure with hypoxia, mild protein calorie malnutrition, and traumatic amputation.The facility's Pain Management and Assessment policy and procedure (1/2026) showed it is the policy of the facility to assess the resident for the presence of pain in order to determine the appropriate interventions purpose - To develop a standardized method for assessing, monitoring, evaluating and documenting pain in both cognitively intact and impaired residents. Residents will receive necessary comfort, exercise greater independence, and enhance dignity through optimizing their ability to perform activities of daily living. If pain is not relieved, give further medication as the physician ordered. If there are no orders, notify the physician of assessment results and obtain an order.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure there was a system in place to assure accurate receipt, dispensing, administration, and reconciliation of controlled substances for 3 of 4 residents (R1, R2, & R3) reviewed for pharmacy services in the sample of 4.The findings include:1. The Proof of Delivery List Report (pharmacy manifest) for R1 showed Oxycontin 5 MG was ordered on 1/16/26 and delivered on 1/17/26. There were 2 cards delivered with 30 pills in each card. The cards were to have Controlled Drug Receipt/Record/Disposition Forms with each card. Card 1 had form 1 and card 2 had form 2. The facility had the Controlled Drug Receipt/Record/Disposition Form dated 1/16/26 form 1 with the Oxycontin 5 MG (milligram) card number 2. The Controlled Drug Receipt/Record/Disposition Form dated 2 dated 1/16/26 and the Oxycontin 5 MG card 1 were missing. On 2/11/26 at 9:48 AM, V5 [NAME] President of Operations stated what she found for R1 is that he had two cards of oxycontin 5 MG delivered on 1/16/26 with 30 tablets in each card. The cards are labeled card 1 and card 2; the narcotic sheet is labeled sheet 1 and sheet 2. The correct sheet is to go with the correct card. Staff pull a label and put it on the card, and everything should match. V5 stated they are missing sheet two and card one of the oxycontin. The right label and card should be with the right sheet. V5 stated it is not a policy; it is just what they are supposed to do. V5 stated there is a missing card of oxycontin. V5 stated she found out that extra medications from the medication cart were being put in the medication cupboard in the medication room and staff were told it is not good practice. V5 stated she told staff she knows they are not counting the medications in the cupboard in the medication room at shift change so those medications are not being accounted for as they should be. The Controlled Drug Receipt/Record/Disposition Forms dated 10/24 25 and 11/8/25 for R1's Oxycodone 5 MG tablets showed on 11/1 at 9:00 AM & 9:30 PM; 11/3 at 9:00 AM; 11/4 at 9:10 AM & 9:00 PM; 11/5 at 9:30 AM; 11/6 at 9:00 AM & 9:30 PM; 11/8 at 8:00 AM; 11/9 at 8:00 AM; 11/10 at 9:00 AM; 11/11 at 8:15 AM; 11/12 at 4:00 AM and 12:00 AM; 11/13 at 8:00 AM; 11/14 at 8:57 AM; 11/15 at 8:30 AM & 9:00 PM; 11/16 at 9:00 PM; 11/17 at 8:15 AM; 11/19 at 8:15 AM; 11/20 at 9:00 AM; 11/21 – no time documented; 11/22 at 9:00 AM; 11/23 at 9:00 AM; 11/24 at 8:50 AM; and 11/25 at 8:00 AM these doses were subtracted on the form but not documented as given on R1's November 2025 Medication Administration Record (MAR). The Face Sheet dated 2/10/26 for R1 showed diagnoses including chronic obstructive pulmonary disease, major depressive disorder, alcohol abuse, hypertension, hyperlipidemia, hypothermia, superficial frostbite, traumatic ischemia of muscle, homelessness, nicotine dependence, lower leg partial traumatic amputation below knee, reduced mobility, acute post hemorrhagic anemia, hypokalemia, disorders of phosphorus metabolism, type 2 diabetes mellitus, acute respiratory failure with hypoxia, mild protein calorie malnutrition, and traumatic amputation. The facility's Controlled Substance Storage policy (10/25/2014) showed the Director of Nursing in collaboration with the consultant pharmacist, maintains the facility's compliance with federal and state laws and regulations in the handling of controlled substances. A controlled substance accountability record is prepared by the pharmacy/facility for all Schedule II, III, IV, and V medications. At each shift change, or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items is conducted by two licensed nurses. Any discrepancy in controlled substance count is reported to the director of nursing and pharmacy immediately. The director or (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	designee investigates and makes every reasonable effort to reconcile all reported discrepancies. The director of nursing documents irreconcilable discrepancies in a report to the administrator. Controlled substance inventory is regularly reconciled to the medication administration record and forms: Controlled Substance Count Record. Current controlled substance accountability records are kept in the MAR, or designated book. Completed accountability records are submitted to the director of nursing and kept on file for 5 years at the facility. 2. The November 2026 Controlled Drug Receipt/Record/Disposition Form for R2's hydromorphone HCL 4 MG tablet was reviewed. It showed to take 1 tablet by mouth, twice daily scheduled; take 1 tablet by mouth twice a day as needed. The form had a sticker on the side of it that showed this was for 2 of 2 cards that were received. The facility received 2 cards of the medication with 30 tablets in each card on 11/6/25. The form started on 11/8/25 at 9:30 PM and the last dose for this card was given on 11/18/25 at 5:20 AM. The form was compared to R2's November 2025 Medication Administration Record and showed the November 2025 Controlled Drug Receipt/Record/Disposition Form for R2 had 6 hydromorphone HCL tablets total signed out as given to the resident but R2's November 2025 MAR did not reflect the administration of the medication. The medication was signed out on 11/11 at 5:30 PM; 11/12 at 7:00 AM, 11:45 AM, and 5:30 PM; 11/13 at 8:15 AM, and 1:00 PM that were not documented as being given to the resident on the MAR. There wasn't a Controlled Drug Receipt/Record/Disposition Form for R2 for the other card hydromorphone HCL 4MG, 30 tablets that was delivered to the facility on [DATE]. The Controlled Drug Receipt/Record/Disposition Form for R2's hydromorphone HCL 4 MG tablet showed there were 2 cards delivered on 12/2/25 and this sheet was started on 12/10/25 and went through 12/29/25. The medication administered according to this form was compared to R2's December 2025 MAR and showed 9 pills were shown as being administered to R2 on the Controlled Drug Receipt/Record/Disposition form but were not signed out as being given to the resident on his December 2025 MAR. There wasn't a Controlled Drug Receipt/Record/Disposition Form for R2 for the other card of hydromorphone HCL 4MG, 30 tablets that was delivered to the facility on [DATE]. The January 2026 MAR for R2 showed on 1/1 at 7:37 AM, 1/3 at 6:58 AM, 1/4 at 11:53 PM and 1/13 at 7:15 AM he was given hydromorphone by two nurses. There wasn't a Controlled Drug Receipt/Record/Disposition Form for R2 for the administration and reconciliation of this medication. The delivery manifest from the pharmacy for R1's controlled medications showed Hydromorphone HCL 4 MG tablets were delivered on the following dates: on 11/6/25 one card of 30 pills and a second card with 30 pills; on 12/2/25 one card of 30 pills and a second card of 30 pills.; on 12/19/25 one card with 30 pills and a second card with 30 pills; 1/30/26 one card with 30 pills; and 2/7/26 one card with 30 pills. The Controlled Drug Receipt/Record/Disposition forms that the facility had for R1 were for the 11/6/25 second card; the 12/2/25 second card; and 2/7/26 current card of pills. The rest of the forms could not be located. On 2/13/26 at 2:20 PM, V5 [NAME] President of Operations stated pharmacy doesn't do reconciliation of narcotics. They look at current medications and narcotics but not previous medications. The clinical managers would do that. Typically, it would be the DON (Director of Nursing) and she is new. They typically do random audits and pick a sample of residents to review to look at the count sheets with the MAR and medications. This is typically done monthly. The pharmacy sends manifests every day. There isn't a policy for this, it is just what is preferred to be done. We also would do it if there (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was a concern about medications. On 2/17/26 at 11:52 AM V5 stated she spoke with V15 Registered Nurse/previous DON and she said that she was doing the audits (manifest, narcotic, sheets and MARS). V5 stated she told V15 if she had been doing them, she would have caught this problem and that is why that process was put in place. V5 said V15 would not commit one way or another on it during the interview. No records were available for the audits. 3. R3's face sheet shows she was admitted to the facility on [DATE] with multiple diagnoses including pressure ulcer of sacral region, stage 4. R3's December 2025 MAR shows an order for Morphine Sulfate ER Extended Release 1 tablet by mouth twice daily for severe pain. The order was discontinued on 12/10/25. A new order for Morphine Sulfate ER 30 mg tablet three times a day was started on 12/30/25. R3's controlled drug receipt/record/disposition form for Morphine sulfate tablets 15 mg ER documents 30 tablets were dispensed on 11/16/25. The record shows on 12/31/25 at 9:00 AM, V8 signed out 2 tablets noting in parenthesis R3's order increased from 15 mg to 30 mg and marked error-not given. The entire line on the record is crossed off, leaving the count at 20. The next line shows V8 signing 1 tablet out for the same day, with an earlier time of 7:00 AM. The card was destroyed with 19 tablets. R3's Morphine Sulfate ER 30 mg tablet-controlled drug sheet shows on 12/31/25, V8 also signed out 1 tablet at 9:00 AM. On 2/13/26 at 3:00 PM, V5 said controlled medications should not be signed out after they have been discontinued. R3's manifest list of controlled medications, shows on 11/7/25, Hydrocodone/APAP 5-325 mg tablets, Rx number 11358133/001 and 002, each card with 30 tablets, 60 tablets in total. The controlled drug receipt record forms were requested, and the facility could not provide any documentation of receipt or destruction of the 60 tablets.