STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155139	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Woods Village	2233 W Jefferson St Kokomo, IN 46901

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. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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	Based on observation, interview and record review, the facility failed to ensure narcotic medications were free from theft of an employee for 2 of 3 residents reviewed for misappropriation of property. (Resident B and C) The deficient practice was corrected on 7/29/25, prior to the start of the survey, and was therefore past noncompliance.Findings include:During an interview, on 12/16/25 at 11:34 a.m., the Director of Nursing (DON) indicated Resident B had requested a pain pill on 7/26/25. LPN 4 was unable to find her oxycodone (narcotic pain medication) or the medication count sheet. LPN 4 called the pharmacy and was informed Resident B should have the narcotics available at the facility. LPN 4 then reported the missing narcotics and an investigation was started. During the investigation, it was discovered Resident C also had narcotic medication and a medication count sheet missing. The facility determined LPN 2 had stolen the narcotics. LPN 2 was terminated from the facility.1. The clinical record for Resident B was reviewed on 12/16/25 at 1:30 p.m. The diagnoses included, but were not limited to, a pathological fracture of the left shoulder, malignant neoplasm of the left lung, malignant neoplasm of the bone, osteoarthritis, and generalized anxiety disorder.A physician's order, dated 7/22/25, indicated to administer oxycodone 10 milligrams (mg) every eight hours as needed for moderate pain. 2. The clinical record for Resident C was reviewed on 12/16/25 at 2:00 p.m. The diagnoses included, but were not limited to, acute pain due to trauma, periprosthetic fracture around the internal prosthetic right knee joint, fracture of the upper end of the right tibia, and fracture of the rib on the left side. A physician's order, dated 7/14/25, indicated to administer oxycodone-acetaminophen 7.5-325 mg every four hours as needed for moderate pain. In a typed facility statement, dated 10/7/25, Qualified Medication Aide (QMA) 6 indicated the evening nurse had conducted a medication count and handed the medication cart keys to LPN 2 at the beginning of LPN 2's shift. At 1:30 a.m., on 7/26/25, LPN 2 took the medication cart into the hallway. LPN 2 had disappeared for at least 30 minutes, without telling the QMA or the CNAs where she was twice during her shift. After she disappeared the second time and came back, LPN 2 indicated she was not feeling well and wanted to go home. Between 3:30 and 3:40 a.m., LPN 2 handed QMA 6 her keys to the medication cart and left without waiting for a nurse to arrive to relieve her. LPN 2 did not count the medication cart with QMA 6 or report on the residents prior to clocking out and leaving the facility.During an observation, on 12/16/25 at 1:45 p.m., the Executive Director (ED) showed a video on her computer of LPN 2 removing narcotics from the narcotic drawer of the medication cart, on 7/26/25 at 2:23 a.m. LPN 2 then placed a jacket on her medication cart and pushed the cart to a darkened spot halfway down the hallway. At 2:25 a.m., LPN 2 took a medication card from the narcotic box, placed it inside the black jacket she had picked up off the cart, and wrapped the narcotic card inside the jacket. LPN 2 then placed the jacket back on the cart and pushed the medication cart back to the nurses' station. At 2:26 a.m., she placed the jacket in a bag sitting at the nurse's station after another employee left the area. At 2:32 a.m., she took the narcotic count sheet book from the medication cart, sat down at the desk for a few seconds, then took the narcotic book to the locked medication room. At 2:34 a.m., she brought the narcotic book back to the medication cart and placed it on the cart. During an interview, on 12/16/25 at 2:10 p.m., the DON provided an untitled document, dated 7/25/25-7/26/25, and indicated the document was LPN 2's time sheet. The time sheet indicated LPN 2 clocked in on 7/25/25 at 10:14 p.m., and clocked out on 7/26/25 at 3:48 a.m. The DON indicated LPN 2 had texted the scheduler and indicated she was sick and needed to go home. LPN 2 did not wait for the nurse to replace her to get to the facility prior to leaving. During a telephone interview, on 12/16/25 at 4:00 p.m., LPN 4 indicated on 7/26/25 at 2:00 p.m., she went to administer Resident B a pain pill and there were no pain pills in the narcotic drawer for Resident B. She called the Nurse Practitioner (NP) and was told the resident had a script filled on 7/21/25 for 38 pills, and the resident should have approximately 25 pills left. LPN 4 notified the Nurse Practitioner no narcotic medications or medication count sheet was available. LPN 4 immediately called the DON and notified her of the missing narcotics. A current facility policy, titled Abuse Prohibition, Reporting and Investigation, dated February 2010 and provided by the Executive Director (ED) on 12/15/25 at 12:15 p.m., indicated .Misappropriation of Resident Funds or Property-Deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's property or money without the resident's consent A current facility policy, titled Controlled Substances: Storage, Documentation, Inventory and Destruction (Includes Fentanyl Patch Removal and Destruction), dated 11/24 and provided by the Executive Director (ED) on 12/15/25 at 12:15 p.m., indicated .To prevent diversion, improper use and accidents related to controlled substances all controlled substances will be