STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Capitol Nursing & Rehabilitation Center	2010 N Capitol Ave Indianapolis, IN 46202

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 - Some	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview and record review, the facility failed to ensure residents' right to be free from misappropriation of their narcotic medication for 4 of 4 residents reviewed for misappropriation. (Residents C, D, E, and F)Findings include:1.An interview was conducted with the Director of Nursing Services (DNS) on 1/28/26 at 10:59 a.m. The DNS indicated there were about thirty fentanyl patches unaccounted for. At 3:30 p.m., the DNS indicated the Fentanyl/Duragesic Controlled Substance Record logs should have been completed by the nurse who removed the old fentanyl patch and applied the new fentanyl patch every 72 hours. It should have been the same nurse for removal as for new application, and a different nurse for the witnessed entries. The logs didn't make any sense, because Licensed Practical Nurse (LPN) 4 documented as the witness to Register Nurse (RN) 2's application, but they didn't even work the same shift. Once each log was completed, it was supposed to be filed and uploaded into the residents' electronic clinical record. There were multiple logs that were missing. An interview was conducted with the DNS on 1/29/25 at 10:53 a.m., when she provided the July, 2025 and one undated Shift Change Verification of Controlled Substances (12 hour) forms. She indicated the undated form was either for August, 2025 or September, 2025. She was unsure which, and the form for the other month was missing. The DNS indicated no one at the facility routinely reviewed residents' narcotic logs for accuracy and to assure that all narcotic medication was accounted for. She only reviewed the narcotic logs, if staff alerted her to a discrepancy. She thought Pharmacist 6 reviewed narcotic logs monthly during pharmacy medication reviews, but she was unsure. She discussed the missing fentanyl patches with Pharmacist 6, and he provided the delivery information for her during the investigation. She discussed with Pharmacist 6 as to why the pharmacy would send more fentanyl patches, after they just sent a month's worth. Since this occurred, she reviewed the narcotic logs more often. Their nurse practitioner discussed the issue with her coworkers as well, in regard to notifying her if they received requests for narcotic prescriptions on the weekends. They discovered most narcotic prescription requests from RN 2 and LPN 4 occurred on the weekend, when there was an on-call nurse practitioner working. The facility's investigation proved there were unaccounted for fentanyl patches, based on the amount delivered minus what was ordered to be administered and the amount of fentanyl patches remining. She and the ADNS interviewed RN 2 and LPN 4 about the fentanyl patches that were unaccounted for. An interview was conducted with the Clinical Director of Resident F's hospice company on 1/29/26 at 12:49 p.m. She indicated she was the supervisor of the hospice nurse who first discovered the fentanyl patch issue at the end of September, 2025 at the facility. Resident F had just been admitted to hospice. Resident F was due for her fentanyl patch to be changed, and the hospice nurse asked the facility staff to apply one, but there were no fentanyl patches available for application. It didn't make sense, because Resident F just had a batch of patches delivered. a. Resident F's physician's order indicated staff were to apply a 72-hour fentanyl (25 mcg/hr [hour]) patch every three days. The July, August, and September, 2025 medication administration records (MAR) indicated the above (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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	referenced fentanyl patch was applied on the following dates: 7/3/25, 7/6/25, 7/9/25, 7/12/25, 7/15/25, 7/18/25, 7/21/25, 7/124/25, 7/27/25, 7/30/25, 8/8/25, 8/11/25, 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/26/25, 8/29/25, 9/1/25, 9/4/25, 9/7/25, 9/10/25, 9/13/25, 9/16/25, 9/19/25, 9/22/25, 9/25/25, and 9/28/25. The only staff to apply these fentanyl patches were RN (Registered Nurse) 2 and LPN (Licensed Practical Nurse) 4, except on 8/17/25. There were no corresponding Fentanyl/Duragesic Controlled Substance Record logs for the applications of fentanyl patches from 7/1/25 to 8/13/25 in Resident F's clinical record. The corresponding 8/14/25 to 9/29/25 Fentanyl/Duragesic Controlled Substance Record logs contradicted the August and September, 2025 MARs. The logs indicated fentanyl patches were applied on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/29/25, 8/31/25, 9/4/25, 9/7/25 at 6:00 a.m., 9/7/25 at 6:00 p.m., 9/10/25 at 6:00 a.m., 9/10/25 at 6:00 p.m., 9/12/25, 9/13/25, 9/14/25, 9/15/25, 9/16/25, 9/18/25, 9/20/25, 9/26/25, 9/27/25, 9/28/25, and 9/29/25. The logs indicated there were no witnesses for the fentanyl patch removals on the following dates: 8/14/25, 8/17/25, 8/20/25, and 8/23/25. The logs indicated there was no fentanyl patch removal on 8/25/25, when the new patch was applied. The logs indicated RN 2 was her own witness to patch removal on the following dates: 9/7/25, 9/10/25, 9/12/25, 9/13/25, 9/14/25, 9/16/25, 9/18/25, 9/20/25, 9/26/25, 9/28/29, and 9/29/29. The nurse who signed off on the MARs as having applied the fentanyl patch did not always match the nurse who signed off on the logs as having applied the fentanyl patch. The pharmacy documentation, included in the investigative file into Resident F's fentanyl patch diversion, was provided by the DNS on 1/28/26 at 10:45 a.m. It indicated, between 7/5/25 and 9/28/25, Resident F was delivered 49 fentanyl patches, and 13 of them were unaccounted for. b. Resident C's physician's order indicated staff were to apply a 72-hour fentanyl patch (75 mcg/hr) every three days. The July, August, and September, 2025 MARs indicated the above referenced fentanyl patch was applied every three days, as ordered, except on 8/20/25, because the medication was unavailable. They indicated fentanyl patches were applied on the following dates: 7/3/25, 7/6/25, 7/9/25, 7/12/25, 7/15/25, 7/18/25, 7/21/25, 7/124/25, 7/27/25, 7/30/25, 8/2/25, 8/5/25, 8/8/25, 8/11/25, 8/14/25, 8/17/25, 8/23/25, 8/26/25, 8/29/25, 9/1/25, 9/4/25, 9/7/25, 9/10/25, 9/13/25, 9/16/25, 9/19/25, 9/22/25, 9/25/25, and 9/28/25. The only staff to apply these fentanyl patches were RN 2 and LPN 4. There were no corresponding Fentanyl/Duragesic Controlled Substance Record logs for the applications of fentanyl patches from 7/1/25 to 8/13/25 in Resident C's clinical record. The corresponding 8/14/25 to 9/28/25 Fentanyl/Duragesic Controlled Substance Record logs contradicted the August and September, 2025 MARs. The logs indicated fentanyl patches were applied on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/25/25, 8/28/25, 9/1/25, 9/4/25, 9/7/25, 9/9/25, 9/10/25, 9/12/25, 9/14/25, 9/19/25, 9/21/25, 9/24/25, 9/26/25, and 9/28/25. The logs indicated there were no witnesses for the fentanyl patch removals on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 9/1/25, and 9/28/25. The logs indicated there was no fentanyl patch removal on 8/25/25 and 9/28/25, when the new patches were applied. The logs indicated RN 2 was her own witness to patch removal on the following dates: 9/7/25, 9/10/25, 9/12/25, 9/14/25, 9/19/25, 9/21/25, 9/24/25, and 9/26/25. The nurse who signed off on the MARs as having applied the fentanyl patch did not always match the nurse who signed off on the logs as having applied the fentanyl patch. The pharmacy documentation, included in the investigative file into Resident C's fentanyl patch diversion, was provided by the DNS on 1/28/26 at 10:45 a.m. It indicated, between 7/5/25 and 9/28/25, Resident C was delivered 31 fentanyl patches, and 4 of them were unaccounted for. An interview was conducted with the DNS on 1/29/25 at 10:53 a.m., when she provided the July, 2025 and one undated Shift Change Verification of Controlled Substances (12 hour) forms. She indicated the undated form was either for August, 2025 or September, 2025. She was unsure which, and there was no (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	form for the other month. c. Resident E's physician's order indicated staff were to apply a 72-hour fentanyl (25 mcg/hr) patch every three days. The July, August, and September, 2025 MARs indicated the above referenced fentanyl patch was applied on the following dates: 7/3/25, 7/6/25, 7/9/25, 7/12/25, 7/15/25, 7/18/25, 7/21/25, 7/24/25, 7/27/25, 7/30/25, 8/2/25, 8/5/25, 8/8/25, 8/11/25, 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/26/25, 8/29/25, 9/4/25, 9/7/25, 9/10/25, 9/13/25, 9/16/25, 9/19/25, 9/22/25, 9/25/25, and 9/28/25. The only staff to apply these fentanyl patches were RN 2 and LPN 4, except on 8/17/25. There were no corresponding Fentanyl/Duragesic Controlled Substance Record logs for the applications of fentanyl patches from 7/1/25 to 8/13/25 in Resident E's clinical record. The corresponding 8/14/25 to 9/29/25 Fentanyl/Duragesic Controlled Substance Record logs contradicted the August and September, 2025 MARs. The logs indicated fentanyl patches were applied on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/26/25, 9/4/25, 9/7/25, 9/10/25, twice on 9/12/25 at 6:00 a.m., 9/13/25, 9/14/25, 9/15/25, 9/18/25, 9/25/25, 9/27/25, 9/28/25, and 9/29/25. The logs indicated there were no witnesses for the fentanyl patch removals on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/26/25, 9/25/25, 9/27/25, 9/28/25, and 9/29/25. The logs indicated there was no fentanyl patch removal on 9/25/25, 9/27/25, 9/28/25, and 9/29/25 when the new patch was applied. The logs indicated RN 2 was her own witness to patch removal on the following dates: 9/7/25, 9/10/25, twice on 9/12/25, 9/13/25, 9/14/25, 9/15/25, and 9/18/25. The nurse who signed off on the MARs as having applied the fentanyl patch did not always match the nurse who signed off on the logs as having applied the fentanyl patch. The pharmacy documentation, included in the investigative file into Resident E's fentanyl patch diversion, was provided by the DNS on 1/28/26 at 10:45 a.m. It indicated, between 7/5/25 and 9/28/25, Resident E was delivered 40 fentanyl patches, and 14 of them were unaccounted for. d. Resident D's physician's order indicated staff were to apply a 72-hour fentanyl (50 mcg/hr) patch every three days. The staff were to verify placement of the fentanyl patch, every shift. The July, August, and September, 2025 MARs indicated the above referenced fentanyl patch was applied on the following dates: 7/3/25, 7/6/25, 7/9/25, 7/12/25, 7/15/25, 7/18/25, 7/21/25, 7/24/25, 7/27/25, 7/30/25, 8/2/25, 8/5/25, 8/8/25, 8/11/25, 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/26/25, 8/29/25, 9/1/25, 9/4/25, 9/7/25, 9/10/25, 9/13/25, 9/16/25, 9/19/25, 9/22/25, 9/25/25, and 9/28/25. The only staff to apply these fentanyl patches were RN (Registered Nurse) 2 and LPN (Licensed Practical Nurse) 4, except on 8/17/25. There were no corresponding Fentanyl/Duragesic Controlled Substance Record logs for the applications of fentanyl patches from 7/1/25 to 8/13/25 or from 9/11/25 to 9/28/25 in Resident D's clinical record. The corresponding 8/14/25 to 9/29/25 Fentanyl/Duragesic Controlled Substance Record logs contradicted the August and September, 2025 MARs. The logs indicated fentanyl patches were applied on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/24/25, 8/26/25, 8/28/25, 8/29/25, 9/1/25, 9/2/25, twice on 9/4/25, 9/7/25, 9/8/25, and 9/10/25. The logs indicated there were no witnesses for the fentanyl patch removals on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/24/25, and 8/26/25. The logs indicated there was no fentanyl patch removal on 8/26/25, when the new patch was applied. The logs indicated RN 2 was her own witness to patch removal on the following dates: 8/28/25, 8/29/25, 9/1/25, 9/2/25, twice on 9/4/25, 9/7/25, 9/8/25, and 9/10/25. The nurse who signed off on the MARs as having applied the fentanyl patch did not always match the nurse who signed off on the logs as having applied the fentanyl patch. The pharmacy documentation, included in the investigative file into Resident D's fentanyl patch diversion, was provided by the DNS on 1/28/26 at 10:45 a.m. It indicated, between 7/5/25 and 9/28/25, Resident D was administered 40 fentanyl patches and 19 of them were unaccounted for. The documented interview, dated 9/30/25, with RN 2, conducted by the ADNS and DNS, documented by the ADNS, and included in the investigative file into (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident C's, D's, E's, and F's fentanyl patch diversion, was provided by the DNS on 1/28/26 at 10:45 a.m. It indicated, On Tuesday September 30th 2025 the DON [Director of Nursing, also known as DNS] spoke with [name of title of RN 2] regarding Fentanyl patches narcotic count error flowsheet, [name of RN 2] stated that she puts the Fentanyl patches on due to [name and title of LPN 4] is allergic to Fentanyl. DON explained to [name of RN 2] that she needed to take a urine drug test, [Name of RN 2] complied [sic] drug test negative, [name of RN 2] stated that yes she did apply patches but only because the other nurse said that she was allergic to Fentanyl. DON explained to nurse that she is suspended during investigation. [Name of RN 2] then exited the building. RN 2's Employee Communication form, dated 10/16/25, indicated there was an incident on 9/30/25 regarding policy/procedure violation of controlled substances, code of ethics, and gross carelessness. It indicated, Employee failed on multiple occasions to follow [name of facility's] Controlled substances: Storage, Documentation, Inventory and Destruction (Includes Fentanyl Patch Removal and Destruction) policy. Continued policy violations include.Gross Carelessness and Code of ethics. She was terminated on 10/16/25. The documented interview, dated 9/30/25, with LPN 4, conducted by the ADNS and DNS, documented by the ADNS, and included in the investigative file into Resident C's D's E's and F's fentanyl patch diversion, was provided by the DNS on 1/28/26 at 10:45 a.m. It indicated, On Tuesday September 30, 2025 the DON spoke with [name and title of LPN 4] regarding Fentanyl patches narcotic count errors on flowsheet, [name of LPN 4] stated that she is allergic to Fentanyl and that [name and title of RN 2] puts the patches on the resident, DNS explained to nurse [name of LPN 4] that she needs to take s [sic] drug test [name of LPN 4] stated that she took a Percocet earlier that morning due to back pain. Urine Drug test was given and was positive for opiods [sic.] DON explained to nurse that she was suspended during investigation [name of LPN 4] then left the building. LPN 4's Employee Communication form, dated 10/16/25, indicated there was an incident on 9/30/25 regarding policy/procedure violation of Drug and Alcohol, Controlled substance, Investigation, and code of ethics. It indicated, Employee failed on multiple occasions to follow [name of facility's] Controlled substances: Storage, Documentation, Inventory and Destruction (Includes Fentanyl Patch Removal and Destruction) policy. Employee failed to participate in an active investigation and failed to pass a drug screen during that investigation. Continued violations include.Gross Carelessness and Code of ethics. She was terminated on 10/16/25. During the survey process RN 2, LPN 4, and Pharmacist 6 were unavailable for interviews. The Controlled Substances: Storage, Documentation, Inventory and Destruction policy was provided by the DNS on 1/29/26 at 11:30 a.m. It indicated, Purpose of Policy: To prevent diversion, improper use and accidents related to controlled substances. Policy: It is the policy of this facility that all controlled substances will be stored, recorded, accounted for, and destroyed by state regulation.Documentation 1. When a controlled substance is administered to a resident, it must be recorded in the resident's Medication Administration (MAR) as well as in the resident's Controlled Substances Inventory Record at the time of administration.Inventory of Controlled Substances (Shift to Shift Count.) 6. The Shift Change Verification of Controlled Substances form and addition/removal logs will be maintained in the facility for 24 months. 7. The resident's Controlled Substance Record will be scanned into resident documents. The Abuse Prohibition, Reporting, and Investigation policy was provided by the ED (Executive Director) on 1/23/26 at 4:31 p.m. It indicated, It is the policy of [name of facility] to provide each resident with an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation.Misappropriation of Resident Funds or Property -Deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident' property or money without the resident's consent. Cross Reference F697-The facility failed to verify placement of (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents' fentanyl patches, as ordered. Cross Reverence F755-The facility failed to implement pharmaceutical procedures that assured the accurate acquiring, receiving, dispensing, and administering of narcotic medication. This Citation relates to Intake 2632048. 3.1-28(a)

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	155226	A. Building B. Wing	01/29/2026

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. F697Based on interview and record review, the facility failed to provide residents' pain medication, as ordered, and to verify placement of residents' fentanyl patches, as ordered, for 4 of 4 residents reviewed for pain management. (Residents C, D, E, and F)Findings include:1. The clinical record for Resident C was reviewed on 1/28/26 at 2:33 p.m. The resident's diagnosis included, but was not limited to: chronic pain. The at risk for pain care plan, revised 1/19/26, indicated the resident was non-verbal and staff must anticipate her needs. Staff were to assess for non-verbal indicators of pain and provide intervention, as ordered. An approach was to administer her medications, as ordered, starting 3/17/22. The physician's orders indicated to apply a 72-hour fentanyl patch (75 mcg/hour) every three days, starting 6/8/24 and ending 9/29/25. The August, 2025 medication administration record (MAR) indicated the fentanyl patch was not applied on 8/20/25, because the medication was unavailable. The current physician's order, starting 2/19/23, indicated to verify placement of the fentanyl patch, every shift. The July, August, and September, 2025 MARs indicated the placement of Resident C's fentanyl patch was not verified on the following dates and shifts: second shift on 7/11/25, first shift on 7/13/25, first shift on 8/12/25, first shift on 9/12/25, and first shift on 9/27/25. 2. The clinical record for Resident F was reviewed on 1/28/26 at 1:56 p.m. The resident's diagnosis included, but was not limited to: chronic pain. The pain assessment, dated 9/23/25, indicated a pain assessment interview was not conducted, because Resident F was rarely/never understood. The staff assessment for pain indicated she had non-verbal sounds (crying, whining, gasping, moaning, or groaning) in the last five days as indicators of pain or possible pain. The resident's indicators of pain or possible pain were observed daily in the last five days. The at risk for pain care plan, starting 6/14/23 and revised 10/6/25, indicated an approach was to administer her medications, as ordered. The physician's orders indicated to apply a 72-hour fentanyl (25 mcg/hour) patch every three days, starting 4/7/25 and ending 8/1/25; starting 8/1/25 and ending 8/5/25, and starting 8/8/25 and ending 9/29/25.The July and August, 2025 MAR indicated a fentanyl patch was applied on 7/30/25, but the next one was not applied until 8/8/25, (missing two ordered applications). The August, 2025 MAR indicated the fentanyl patch was not applied on 8/4/25, because the medication was unavailable. The physician's order, from 8/12/25 to 12/14/25, indicated staff were to verify placement of the fentanyl patch, every shift. The September, 2025 MAR indicated the placement of Resident F's fentanyl patch was not verified on first shift on 9/12/25 and first shift on 9/17/25. 3. The clinical record for Resident E was reviewed on 1/29/26 at 11:53 a.m. The resident's diagnosis included, but was not limited to: chronic pain. The at risk for pain care plan, starting 7/13/23 and revised 11/12/25, indicated an approach was to administer medications, as ordered. The physician's order, starting 6/29/24 and ending on 9/29/25, indicated staff were to apply a 72-hour fentanyl (25 mcg/hour) patch every three days. The September, 2025 MAR indicated the fentanyl patch was not applied on 9/1/25, because a new prescription was needed. The physician's order, from 5/19/25 to 1/16/26, indicated to verify placement of the fentanyl patch, every shift. The July, 2025 MAR indicated the placement of Resident E's fentanyl patch was not verified on first shift on 7/13/25 and first shift on 7/22/25. 4. The clinical record for Resident D was reviewed on 1/29/26 at 12:16 p.m. The resident's diagnosis included, but was not limited to: neuralgia (sharp, severe nerve pain). The at risk for pain care plan, starting 9/3/15 and revised 12/15/25, indicated an approach was to administer medications, as ordered. The physician's order, starting 2/21/25 and ending 7/15/25; 7/15/25 to 9/21/25; 9/21/25 to 90/22/25; and 9/22/25 to 9/29/25, indicated staff were to apply a 72-hour fentanyl (50 mcg/hour) patch every three days. Starting 1/2/19, the staff were to verify placement of the fentanyl patch on every shift. The September, 2025 MAR (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated the placement of Resident D's fentanyl patch was not verified on first shift on 9/12/25. An interview was conducted with the Director of Nursing Services (DNS) on 1/28/26 at 10:59 a.m. The DNS indicated there were issues, involving two nurses and fentanyl patch diversion, on the unit where Resident C, Resident D, Resident E, and Resident F resided. The Pain Management policy was provided by the DNS on 1/29/26 at 11:30 a.m. It indicated, It is the policy of [name of facility] to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, including pain management.Physician orders for pain medication will be prescribed based upon the resident's intensity of pain.A plan of care will be written with the initiation of pain medication and individualized to the resident. This citation relates to Intake 2632048.3.1-37(a)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to implement pharmaceutical procedures that assured the accurate acquiring, receiving, dispensing, and administering of narcotic medication; to ensure medication records were in order; and ensure that an account of all controlled medications was maintained and periodically reconciled for 4 of 4 residents reviewed for pain management. (Residents C, D, E, and F)Findings include:1. The clinical record for Resident F was reviewed on 1/28/26 at 1:56 p.m. The resident's diagnosis included, but was not limited to: chronic pain. An interview was conducted with the Clinical Director of Resident F's hospice company on 1/29/26 at 12:49 p.m. She indicated she was the supervisor of the hospice nurse who first discovered the fentanyl patch issue at the end of September, 2025 at the facility. Resident F had just been admitted to hospice. Resident F was due for her fentanyl patch to be changed, and the hospice nurse asked the facility staff to apply one, but there were no fentanyl patches available for application. It didn't make sense, because Resident F just had a batch of patches delivered. The pain assessment, dated 9/23/25, indicated a pain assessment interview was not conducted, because Resident F was rarely/never understood. The staff assessment for pain indicated she had non-verbal sounds (crying, whining, gasping, moaning, or groaning) in the last five days as indicators of pain or possible pain. Her indicators of pain or possible pain were observed daily in the last five days. The physician's orders indicated to apply a 72-hour fentanyl (25 mcg/hr [hour]) patch every three days, starting 4/7/25 and ending 8/1/25; starting 8/1/25 and ending 8/5/25, and starting 8/8/25 and ending 9/29/25. The July, August, and September, 2025 MARs indicated the above referenced fentanyl patch was applied on the following dates: 7/3/25, 7/6/25, 7/9/25, 7/12/25, 7/15/25, 7/18/25, 7/21/25, 7/124/25, 7/27/25, 7/30/25, 8/8/25, 8/11/25, 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/26/25, 8/29/25, 9/1/25, 9/4/25, 9/7/25, 9/10/25, 9/13/25, 9/16/25, 9/19/25, 9/22/25, 9/25/25, and 9/28/25. The only staff to apply these fentanyl patches were RN 2 and LPN (Licensed Practical Nurse) 4, except on 8/17/25. There were no corresponding Fentanyl/Duragesic Controlled Substance Record logs for the applications of fentanyl patches from 7/1/25 to 8/13/25 in Resident F's clinical record. The corresponding 8/14/25 to 9/29/25 Fentanyl/Duragesic Controlled Substance Record logs contradicted the August and September, 2025 MARs. The logs indicated fentanyl patches were applied on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/29/25, 8/31/25, 9/4/25, 9/7/25 at 6:00 a.m., 9/7/25 at 6:00 p.m., 9/10/25 at 6:00 a.m., 9/10/25 at 6:00 p.m., 9/12/25, 9/13/25, 9/14/25, 9/15/25, 9/16/25, 9/18/25, 9/20/25, 9/26/25, 9/27/25, 9/28/25, and 9/29/25. The logs indicated there were no witnesses for the fentanyl patch removals on the following dates: 8/14/25, 8/17/25, 8/20/25, and 8/23/25. The logs indicated there was no fentanyl patch removal on 8/25/25, when the new patch was applied. The logs indicated RN 2 was her own witness to patch removal on the following dates: 9/7/25, 9/10/25, 9/12/25, 9/13/25, 9/14/25, 9/16/25, 9/18/25, 9/20/25, 9/26/25, 9/28/29, and 9/29/29. The nurse who signed off on the MARs as having applied the fentanyl patch did not always match the nurse who signed off on the logs as having applied the fentanyl patch. The pharmacy documentation, included in the investigative file into Resident F's fentanyl patch diversion, was provided by the DNS on 1/28/26 at 10:45 a.m. It indicated, between 7/5/25 and 9/28/25, Resident F was delivered 49 fentanyl patches, and 13 of them were unaccounted for. RN 2, LPN 4, and Pharmacist 6 were unavailable for interviews. 2. The clinical record for Resident C was reviewed on 1/28/26 at 2:33 p.m. The resident's diagnosis included, but was not limited to: chronic pain. The pain assessment, dated 7/17/25, indicated a pain assessment interview was not conducted, because Resident C was rarely/never understood. The staff assessment for pain indicated she had facial expressions (grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or (continued on next page)

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	155226	A. Building B. Wing	01/29/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	jaw) in the last five days as indicators of pain or possible pain. Her indicators of pain or possible pain were observed daily in the last five days. The physician's order, starting 6/8/24 and ending on 9/29/25, indicated staff were to apply a 72-hour fentanyl (75 mcg/hr) patch every three days. The July, August, and September, 2025 MARs indicated the above referenced fentanyl patch was applied every three days, as ordered, except on 8/20/25, because the medication was unavailable. They indicated fentanyl patches were applied on the following dates: 7/3/25, 7/6/25, 7/9/25, 7/12/25, 7/15/25, 7/18/25, 7/21/25, 7/124/25, 7/27/25, 7/30/25, 8/2/25, 8/5/25, 8/8/25, 8/11/25, 8/14/25, 8/17/25, 8/23/25, 8/26/25, 8/29/25, 9/1/25, 9/4/25, 9/7/25, 9/10/25, 9/13/25, 9/16/25, 9/19/25, 9/22/25, 9/25/25, and 9/28/25. The only staff to apply these fentanyl patches were RN 2 and LPN 4. There were no corresponding Fentanyl/Duragesic Controlled Substance Record logs for the applications of fentanyl patches from 7/1/25 to 8/13/25 in Resident C's clinical record. The corresponding 8/14/25 to 9/28/25 Fentanyl/Duragesic Controlled Substance Record logs contradicted the August and September, 2025 MARs. The logs indicated fentanyl patches were applied on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/25/25, 8/28/25, 9/1/25, 9/4/25, 9/7/25, 9/9/25, 9/10/25, 9/12/25, 9/14/25, 9/19/25, 9/21/25, 9/24/25, 9/26/25, and 9/28/25. The logs indicated there were no witnesses for the fentanyl patch removals on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 9/1/25, and 9/28/25. The logs indicated there was no fentanyl patch removal on 8/25/25 and 9/28/25, when the new patches were applied. The logs indicated RN 2 was her own witness to patch removal on the following dates: 9/7/25, 9/10/25, 9/12/25, 9/14/25, 9/19/25, 9/21/25, 9/24/25, and 9/26/25. The nurse who signed off on the MARs as having applied the fentanyl patch did not always match the nurse who signed off on the logs as having applied the fentanyl patch. The pharmacy documentation, included in the investigative file into Resident C's fentanyl patch diversion, was provided by the DNS on 1/28/26 at 10:45 a.m. It indicated, between 7/5/25 and 9/28/25, Resident C was delivered 31 fentanyl patches, and 4 of them were unaccounted for. An interview was conducted with the DNS on 1/29/25 at 10:53 a.m., when she provided the July, 2025 and one undated Shift Change Verification of Controlled Substances (12 hour) forms. She indicated the undated form was either for August, 2025 or September, 2025. She was unsure which, and there was no form for the other month. RN 2, LPN 4, and Pharmacist 6 were unavailable for interviews. 3. The clinical record for Resident E was reviewed on 1/29/26 at 11:53 a.m. The resident's diagnosis included, but was not limited to: chronic pain. The physician's orders indicated to apply a 72-hour 25 mcg/hr (hour) fentanyl patch every three days, starting 6/29/24 and ending 9/29/25. The July, August, and September, 2025 MARs indicated the above referenced fentanyl patch was applied on the following dates: 7/3/25, 7/6/25, 7/9/25, 7/12/25, 7/15/25, 7/18/25, 7/21/25, 7/24/25, 7/27/25, 7/30/25, 8/2/25, 8/5/25, 8/8/25, 8/11/25, 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/26/25, 8/29/25, 9/4/25, 9/7/25, 9/10/25, 9/13/25, 9/16/25, 9/19/25, 9/22/25, 9/25/25, and 9/28/25. The only staff to apply these fentanyl patches were RN 2 and LPN 4, except on 8/17/25. There were no corresponding Fentanyl/Duragesic Controlled Substance Record logs for the applications of fentanyl patches from 7/1/25 to 8/13/25 in Resident E's clinical record. The corresponding 8/14/25 to 9/29/25 Fentanyl/Duragesic Controlled Substance Record logs contradicted the August and September, 2025 MARs. The logs indicated fentanyl patches were applied on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/26/25, 9/4/25, 9/7/25, 9/10/25, twice on 9/12/25 at 6:00 a.m., 9/13/25, 9/14/25, 9/15/25, 9/18/25, 9/25/25, 9/27/25, 9/28/25, and 9/29/25. The logs indicated there were no witnesses for the fentanyl patch removals on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/26/25, 9/25/25, 9/27/25, 9/28/25, and 9/29/25. The logs indicated there was no fentanyl patch removal on 9/25/25, 9/27/25, 9/28/25, and 9/29/25 when the new patch was applied. The logs indicated RN 2 was her own witness to patch (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removal on the following dates: 9/7/25, 9/10/25, twice on 9/12/25, 9/13/25, 9/14/25, 9/15/25, and 9/18/25. The nurse who signed off on the MARs as having applied the fentanyl patch did not always match the nurse who signed off on the logs as having applied the fentanyl patch. The pharmacy documentation, included in the investigative file into Resident E's fentanyl patch diversion, was provided by the DNS on 1/28/26 at 10:45 a.m. It indicated, between 7/5/25 and 9/28/25, Resident E was delivered 40 fentanyl patches, and 14 of them were unaccounted for. RN 2, LPN 4, and Pharmacist 6 were unavailable for interviews. 4. The clinical record for Resident D was reviewed on 1/29/26 at 12:16 p.m. The resident's diagnosis included, but was not limited to: neuralgia (sharp, severe nerve pain). The physician's order, starting 2/21/25 and ending 7/15/25; 7/15/25 to 9/21/25; 9/21/25 to 90/22/25; and 9/22/25 to 9/29/25, indicated staff were to apply a 72-hour fentanyl (50 mcg/hr) patch every three days. The staff were to verify placement of the fentanyl patch, every shift, starting 1/2/19. The July, August, and September, 2025 MARs indicated the above referenced fentanyl patch was applied on the following dates: 7/3/25, 7/6/25, 7/9/25, 7/12/25, 7/15/25, 7/18/25, 7/21/25, 7/24/25, 7/27/25, 7/30/25, 8/2/25, 8/5/25, 8/8/25, 8/11/25, 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/26/25, 8/29/25, 9/1/25, 9/4/25, 9/7/25, 9/10/25, 9/13/25, 9/16/25, 9/19/25, 9/22/25, 9/25/25, and 9/28/25. The only staff to apply these fentanyl patches were RN 2 and LPN 4, except on 8/17/25. There were no corresponding Fentanyl/Duragesic Controlled Substance Record logs for the applications of fentanyl patches from 7/1/25 to 8/13/25 or from 9/11/25 to 9/28/25 in Resident D's clinical record. The corresponding 8/14/25 to 9/29/25 Fentanyl/Duragesic Controlled Substance Record logs contradicted the August and September, 2025 MARs. The logs indicated fentanyl patches were applied on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/24/25, 8/26/25, 8/28/25, 8/29/25, 9/1/25, 9/2/25, twice on 9/4/25, 9/7/25, 9/8/25, and 9/10/25. The logs indicated there were no witnesses for the fentanyl patch removals on the following dates: 8/14/25, 8/17/25, 8/20/25, 8/23/25, 8/24/25, and 8/26/25. The logs indicated there was no fentanyl patch removal on 8/26/25, when the new patch was applied. The logs indicated RN 2 was her own witness to patch removal on the following dates: 8/28/25, 8/29/25, 9/1/25, 9/2/25, twice on 9/4/25, 9/7/25, 9/8/25, and 9/10/25. The nurse who signed off on the MARs as having applied the fentanyl patch did not always match the nurse who signed off on the logs as having applied the fentanyl patch. The pharmacy documentation, included in the investigative file into Resident D's fentanyl patch diversion, was provided by the DNS on 1/28/26 at 10:45 a.m. It indicated, between 7/5/25 and 9/28/25, Resident D was administered 40 fentanyl patches and 19 of them were unaccounted for. An interview was conducted with the DNS on 1/28/26 at 3:20 p.m. She indicated the Fentanyl/Duragesic Controlled Substance Record logs should have been completed by the nurse who removed the old fentanyl patch and applied the new fentanyl patch every 72 hours. It should have been the same nurse for removal as for new application, and a different nurse for the witnessed entries. The logs didn't make any sense, because LPN 4 documented as the witness to RN 2's application, but they didn't even work the same shift. Once each log was completed, it was supposed to be filed and uploaded into the residents' electronic clinical record. There were multiple logs that were missing. Resident D's missing logs were most disturbing to her, because the logs were missing for fentanyl patch deliveries made only a week earlier. An interview was conducted with the DNS on 1/29/25 at 10:53 a.m., when she provided the July, 2025 and one undated Shift Change Verification of Controlled Substances (12 hour) forms. She indicated the undated form was either for August, 2025 or September, 2025. She was unsure which, and the form for the other month was missing. No one at the facility routinely reviewed residents' narcotic logs for accuracy and to assure that all narcotic medication was accounted for. She only reviewed the narcotic logs, if staff alerted her to a discrepancy. She thought Pharmacist 6 reviewed (continued on next page)

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