STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Crossing and the Lofts	5404 Georgetown Road Indianapolis, IN 46254

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 interview and record review, the facility failed to ensure residents' narcotic medications were protected from diversion resulting in 60 missing Norco (a Schedule II narcotic medication) tablets, for 1 of 3 residents reviewed for misappropriation (Resident L). This deficient practice was corrected by [DATE] prior to the start of the survey and was therefore Past Noncompliance.Findings include: A Facility Reported Incident (FRI) indicated, on [DATE], two cards of Resident L's narcotic medications, for a total of 60 tablets, were found missing from the medication cart. The Executive Director (ED), local law enforcement, consulting pharmacy, and Nurse Practitioner (NP) were notified. Licensed Practical Nurse (LPN) 10 was suspended pending investigation and subsequently terminated. Resident L's clinical record was reviewed on [DATE] at 12:31p.m. Diagnoses on Resident L's profile included, but were not limited to, radiculopathy in the cervical region (pinched nerve in the neck), fibromyalgia (chronic condition causing widespread body pain), carpal tunnel syndrome of an unspecified upper limb (painful condition caused by compressed nerves in the wrist), and intervertebral disc degeneration of lumbar region (lower back). The most recent pain assessment documented on a Pain Observation Tool, dated [DATE], indicated Resident L verbalized severe pain. A physician's order for Resident L, dated [DATE], indicated hydrocodone-acetaminophen (Norco) 5-325 milligrams (mg) give 1 tablet by mouth every 6 hours for pain. A pharmacy packing slip, dated [DATE] at 6:00 a.m., indicated Registered Nurse (RN) 11 signed for receipt of four cards of 30 hydrocodone-acetaminophen 5-325 mg (a total of 120 tablets) for Resident L. A progress note, dated [DATE], indicated at 6:00 a.m. Resident L was found unresponsive. Cardiopulmonary Resuscitation (CPR) was initiated but unsuccessful and the resident was pronounced dead at 6:15 a.m. A Witness Statement by Licensed Practical Nurse (LPN) 6, dated [DATE], indicated she had last seen Resident L's hydrocodone-acetaminophen on [DATE] at the end of her shift. On [DATE] when she returned to work, she found there were two cards of the medication missing, but the count was correct. A narcotic count sheet for Resident L, for hydrocodone-acetaminophen 5-325 mg tablets, was signed as having 45 tablets on [DATE], 19 days after the resident died. Shift Change/Controlled Substance Inventory Tracker sheets (kept on each medication cart in a narcotic tracking binder), indicated Every controlled medication and count sheet added or removed from the medication cart MUST be documented by 2 nurses on the left side. The Shift Change/Controlled Substance Inventory Trackers sheets, dated [DATE] - 12/2925, from 6 of the 6 medication carts utilized on the Health hallways, Heritage hallways, the [NAME] 1 or the [NAME] 2 hallways, indicated two nurses had not signed as the 1st nurse initials or the verified by a 2nd nurse initials, when cards and count sheets for narcotic medications had been added or removed per instructions on the bottom of the sheet. An Employee Corrective Action Form, dated [DATE], indicated LPN 10 was terminated due to performance/policy violation. The violation statement indicated LPN 10 failed to cooperate in an investigation related to drug diversion. In-Service Education sign-in logs, dated [DATE] - [DATE], indicated the topics of the narcotic (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
	155826	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Crossing and the Lofts	5404 Georgetown Road Indianapolis, IN 46254

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	medication log, counting narcotics, and medication administration. Nursing staff documented as having received the education. The interim ED indicated she and Regional Director of Clinical Operations had not been working in the facility when Resident L's narcotic medication had been found missing on [DATE] and therefore were not part of the entire follow-up investigation. During an interview on [DATE] at 11:22 a.m., Unit Manager (UM) 15 indicated she had been involved in the search for the missing narcotic medications on the Heritage hallway. Resident L had died on [DATE] and his hydrocodone-acetaminophen 5-325 mg tablets were found missing on [DATE]. UM 15 indicated she had not worked in the facility at the time of the medications were found missing, but to her knowledge, the narcotics were not recovered. An investigation had been initiated and the evidence gathered pointed to LPN 10 who was a floater nurse in the facility. LPN 10 had been terminated. UM 15 indicated nurses and Qualified Medication Aides (QMAs) were required to count the number of narcotic pills/tablets, the number of cards the narcotic medications were on, and the number of narcotic medication count sheets. During an interview on [DATE] at 11:33 a.m., LPN 6 indicated she and the other nurses routinely worked the same resident assignment and medication cart on the Heritage hallway. On [DATE] while counting the medication cart with a peer, she identified missing cards of medications for deceased Resident L. The number of medications matched the narcotic count sheets, but she knew there had been more cards of hydrocodone-acetaminophen and corresponding count sheets when she had left the prior day. LPN 6 indicated she had immediately notified the prior ED, provided a statement when asked, and management had opened an investigation. LPN 6 indicated as part of the follow-up investigation, nursing staff had been educated on the storage, administration, counting and destruction of narcotic medications. LPN 6 indicated when a resident discharged , the charge nurse or UM notified the DON, and it was the responsibility of the DON to destroy narcotic medications. Narcotics were never destroyed by the nurses working on the hallways. LPN 6 indicated she could not answer as to why Resident L's medication had remained on the medication cart for 15 days after his death, but to her knowledge the missing narcotics were never found. During an interview on [DATE] at 12:55 p.m., the [NAME] President of Risk Management (VPRM) indicated, on Saturday [DATE], QMA 14 was on call for the facility. QMA 14 was notified by LPN 6 that Resident L's hydrocodone-acetaminophen count was correct, but she and RN 13 both remembered the day before there being more cards of the medication in the cart. LPN 6 had questioned if the two cards of medication had already been destroyed. QMA 14 then called the ED who was the abuse coordinator, the DON, and all upper management staff were notified. QMA 14 had contacted the VPRM again, and guidance was given to include counting the narcotic book, cards, and sheets. Subsequently staff found there was a page missing in the narcotic count book (the pages were numbered in sequential order), and a new page for counts had been started in the book. When interviewed, LPN 10 indicated the prior evening the narcotic counts had been correct between evening and night shift. The night shift person had only a new narcotic sheet to go by that had been started by LPN 10, and had no idea there were missing cards. The next morning, [DATE], when LPN 6 and the night shift nurse counted the cart, LPN 6 questioned the number of medication cards. LPN 10 denied the extra cards of medications for Resident L had been in the cart. But the nurse from the evening shift the night before remembered the extra cards had been in the cart. LPN 10 eventually admitted starting a new narcotic count sheet, but indicated the narcotic sheet had already been missing, and the numbers on the narcotic count sheet were gained by counting the medications in the cart. LPN 10 did not admit to ripping the count sheet page out of the narcotic book or taking the two cards of narcotics. LPN 10 had been suspended pending investigation, the police had been contacted, and when LPN stopped taking phone calls or cooperating with the investigation, she had been terminated. During an interview on [DATE] (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Crossing and the Lofts	5404 Georgetown Road Indianapolis, IN 46254

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	at 12:55 p.m., the VPRM indicated the DON was responsible for destruction of narcotic medications. There had been a delay in destruction of Resident L's narcotic medications after the resident died as the facility had been in transition between DON's in [DATE]. The nursing staff had since been educated to include receiving narcotics from the pharmacy, chain of custody, the chain of custody book, shift count of narcotics, and destruction of narcotics. The UM was responsible for notifying the DON when a resident discharged or died, and nurses were supposed to notify the DON again if narcotics remained on the cart more than a few days. The UM would monitor the medication cart and pull narcotics the next day after a resident discharged and take them to the DON if the DON had not retrieved them, monitor for proper documentation on the narcotic tracking sheets, and monitor for drug diversion. The regional staff would provide additional monitoring. On [DATE] at 1:25 p.m., the Regional Director of Clinical Operations provided a Controlled Substance Disposal policy, dated [DATE], and indicated the policy was the one currently being used by the facility. The policy indicated, Medications included in the Drug Enforcement Administration [DEA] classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations.C. All controlled substances remaining in the facility after a resident has been discharged , or the order is discontinued, are disposed of: a. In the facility by the director of nursing and the consultant pharmacist [or other licensed personnel.F. Accountability records or controlled substances that are disposed of or destroyed are maintained with the unused supply until destruction or disposal and then stored for five [5] years or per applicable law or regulation. On [DATE] at 2:03 p.m., the VPRM provided a Medication Controlled Drugs and Security policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, .Narcotics will be kept under double lock and will be counted by off-going nurse at the end of the shift and before keys are passed to next shift.III. d. Narcotics will be counted at change of shift and upon being relieved from duty.IV. a. Controlled drugs as well as the controlled drug count sheets and cards, are counted every shift change by the nurse reporting on duty with the nurse reporting off duty. b. The inventory of the controlled drugs count sheets and number of cards must be recorded on the narcotic records and signed for correctness of count. c. The controlled drug record must be signed by the nurse coming on duty and going off duty to verify that the count of all controlled drugs is correct after the count has been completed.V. c. If the cause of the discrepancy cannot be located and/or the count does not balance, report the matter to the supervisor for immediate investigation. d. Nurses, or qualified medication aides may not leave the unit until directed to do so by the immediate supervisor.VII. a. When the prescribed drug is discontinued, or the resident discharged , the container and control sheet must be removed for drug destruction. A Nurse Shift Change and Walking Rounds policy, undated, indicated, .4. Nurse rounding and report includes but not limited to: a. Medication count for legally accepting the chain of command for drugs. b. A shift audit of the MAR and TAR records with reconciliation if needed. c. The MAR will be audited and reconciled with the narcotics count and PRN medications, as applicable. i. For a drug discrepancy that cannot be resolved, the Director of Nursing/designee will be notified immediately. Ii. Nurses will remain on the unit until the DON/designee releases them.5. Nurses will accept/reject current status of residents, medications and orders and be accountable on his/her shift; reconciliation will be achieved prior to the off-going nurse being released. A Maintaining Chain of Custody Destruction Sheet, effective [DATE], indicated, .When narcotics are discontinued, pull from the med cart and are unable to be given for any reason, they must be destroyed to ensure the chain of custody. The medication must be listed on this form or an appropriate log from the pharmacy. Once the drug is destroyed, it must be in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Crossing and the Lofts	5404 Georgetown Road Indianapolis, IN 46254

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	the presence of 2 nurses and/or pharmacist or per state regulations. Both signatures must be next to the item destroyed on this form. This form must be kept in the facility for a minimum of 2 years. This deficient practice was corrected by [DATE] prior to the start of the survey and was therefore Past Noncompliance. The facility implemented a systemic plan that included monitoring delivery, storage, and counting of narcotic medications; staff education regarding accurate narcotic counts; policy and procedures for medication destruction; and ongoing monitoring by Quality Assurance and Performance Improvement (QAPI). This citation relates to Intake 2701568. 3.1-28(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Crossing and the Lofts	5404 Georgetown Road Indianapolis, IN 46254

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 - Some	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 maintain a system for the reconciliation of controlled medications from 4 of 4 nursing units (Health, Heritage, [NAME] 1 and [NAME] 2), resulting in diversion of at least 60 Norco (hydrocodone-acetaminophen - a Schedule II narcotic medication) tablets from 1 of 4 nursing units reviewed for diversion of narcotics (Heritage hallways). This deficient practice was corrected by [DATE] prior to the start of the survey and was therefore Past Noncompliance.Findings include: A Facility Reported Incident (FRI), indicated on [DATE], 2 cards of Resident L's narcotic medications, for a total of 60 tablets, were found missing from the medication cart. The Executive Director (ED), local law enforcement, consulting pharmacy, and Nurse Practitioner (NP) were notified. Licensed Practical Nurse (LPN) 10 was suspended pending investigation and subsequently terminated. A pharmacy packing slip, dated [DATE] at 6:00 a.m., indicated Registered Nurse (RN) 11 signed for receipt of 4 cards of 30 hydrocodone-acetaminophen 5-325 mg (a total of 120 tablets) for Resident L. A progress notes, dated [DATE], indicated at 6:00 a.m. Resident L was found unresponsive. Cardiopulmonary Resuscitation (CPR) was initiated but unsuccessful and the resident was pronounced dead at 6:15 a.m. A Witness Statement by Licensed Practical Nurse (LPN) 6, dated [DATE], indicated she had last seen Resident L's hydrocodone-acetaminophen on [DATE] at the end of her shift. On [DATE] when she returned to work, she found there were 2 cards of the medication missing, but the count was correct. A narcotic count sheet for Resident L, for hydrocodone-acetaminophen 5-325 mg tablets, was signed as having 45 tablets on [DATE], 19 days after the resident died. Shift Change/Controlled Substance Inventory Tracker sheets (kept on each medication cart in a narcotic tracking binder), indicated Every controlled medication and count sheet added or removed from the medication cart MUST be documented by 2 nurses on the left side. The Shift Change/Controlled Substance Inventory Trackers sheets, dated [DATE] - 12/2925, from 6 of the 6 medication carts utilized on the Health hallways, Heritage hallways, the [NAME] 1 or the [NAME] 2 hallways, indicated 2 nurses had not signed as the 1st nurse initials or the verified by a 2nd nurse initials, when cards and count sheets for narcotic medications had been added or removed per instructions on the bottom of the sheet. During an interview on [DATE] at 12:55 p.m., the [NAME] President of Risk Management (VPRM) indicated, on Saturday [DATE], QMA 14 was on call for the facility. QMA 14 was notified by LPN 6 that Resident L's hydrocodone-acetaminophen count was correct, but she and RN 13 both remembered the day before there being more cards of the medication in the cart. LPN 6 had questioned if the 2 cards of medication had already been destroyed. QMA 14 then called the ED who was the abuse coordinator, the DON, and all upper management staff were notified. QMA 14 had contacted the VPRM again, and guidance was given to include counting the narcotic book, cards and sheets. Subsequently staff found there was a page missing in the narcotic count book (the pages were numbered in sequential order), and a new page for counts had been started in the book. When interviewed, LPN 10 indicated the prior evening the narcotic counts had been correct between evening and night shift. The night shift person had only a new narcotic sheet to go by that had been started by LPN 10, and had no idea there were missing cards. The next morning, [DATE], when LPN 6 and the night shift nurse counted the cart, LPN 6 questioned the number of medication cards. LPN 10 denied the extra cards of medications for Resident L had been in the cart. But the nurse from the evening shift the night before remembered the extra cards had been in the cart. LPN 10 eventually admitted starting a new narcotic count sheet, but indicated the narcotic sheet had already been missing, and the numbers on the narcotic count sheet were gained by counting the medications in the cart. LPN 10 did not admit to ripping the count sheet page out of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Crossing and the Lofts	5404 Georgetown Road Indianapolis, IN 46254

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 - Some	narcotic book or taking the 2 cards of narcotics. LPN 10 had been suspended pending investigation, the police had been contacted, and when LPN stopped taking phone calls or cooperating with the investigation, she had been terminated. During an interview on [DATE] at 12:55 p.m., the VPRM indicated the DON was responsible for destruction of narcotic medications. There had been a delay in destruction of Resident L's narcotic medications after the resident died as the facility had been in transition between DON's in [DATE]. The nursing staff had since been educated to include receiving narcotics from the pharmacy, chain of custody, the chain of custody book, shift count of narcotics, and destruction of narcotics. The UM was responsible for notifying the DON when a resident discharged or died, and nurses were supposed to notify the DON again if narcotics remained on the cart more than a few days. The UM would monitor the medication cart and pull narcotics the next day after a resident discharge and take them to the DON if the DON had not retrieved them, monitor for proper documentation on the narcotic tracking sheets, and monitor for drug diversion. The regional staff would provide additional monitoring. On [DATE] at 1:25 p.m., the Regional Director of Clinical Operations provided a Controlled Substance Disposal policy, dated [DATE], and indicated the policy was the one currently being used by the facility. The policy indicated, .Medications included in the Drug Enforcement Administration [DEA] classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations.C. All controlled substances remaining in the facility after a resident has been discharged , or the order is discontinued, are disposed of: a. In the facility by the director of nursing and the consultant pharmacist [or other licensed personnel.F. Accountability records or controlled substances that are disposed of or destroyed are maintained with the unused supply until destruction or disposal and then stored for five [5] years or per applicable law or regulation. On [DATE] at 2:03 p.m., the VPRM provided a Medication Controlled Drugs and Security policy, undated, and indicated the policy was the one currently being used by the facility. The policy indicated, .Narcotics will be kept under double lock and will be counted by off-going nurse at the end of the shift and before keys are passed to next shift.III. d. Narcotics will be counted at change of shift and upon being relieved from duty.IV. a. Controlled drugs as well as the controlled drug count sheets and cards, are counted every shift change by the nurse reporting on duty with the nurse reporting off duty. b. The inventory of the controlled drugs count sheets and number of cards must be recorded on the narcotic records and signed for correctness of count. c. The controlled drug record must be signed by the nurse coming on duty and going off duty to verify that the count of all controlled drugs is correct after the count has been completed.V. c. If the cause of the discrepancy cannot be located and/or the count does not balance, report the matter to the supervisor for immediate investigation. d. Nurses, or qualified medication aides may not leave the unit until directed to do so by the immediate supervisor.VII. a. When the prescribed drug is discontinued, or the resident discharged , the container and control sheet must be removed for drug destruction. A Nurse Shift Change and Walking Rounds policy, undated, indicated, .4. Nurse rounding and report includes but not limited to: a. Medication count for legally accepting the chain of command for drugs. b. A shift audit of the MAR and TAR records with reconciliation if needed. c. The MAR will be audited and reconciled with the narcotics count and PRN medications, as applicable. i. For a drug discrepancy that cannot be resolved, the Director of Nursing/designee will be notified immediately. Ii. Nurses will remain on the unit until the DON/designee releases them.5. Nurses will accept/reject current status of residents, medications and orders and be accountable on his/her shift; reconciliation will be achieved prior to the off-going nurse being released. A Maintaining Chain of Custody Destruction Sheet, effective [DATE], indicated, When narcotics are (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155826	A. Building B. Wing	02/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Crossing and the Lofts	5404 Georgetown Road Indianapolis, IN 46254

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 - Some	discontinued, pull from the med cart and are unable to be given for any reason, they must be destroyed to ensure the chain of custody. The medication must be listed on this form or an appropriate log from the pharmacy. Once the drug is destroyed, it must be in the presence of 2 nurses and/or pharmacist or per state regulations. Both signatures must be next to the item destroyed on this form. This form must be kept in the facility for a minimum of 2 years. This deficient practice was corrected by [DATE] prior to the start of the survey and was therefore Past Noncompliance. The facility implemented a systemic plan that included monitoring delivery, storage and counting of narcotic medications, staff education regarding accurate narcotic counts and policy and procedures for medication destruction, and ongoing monitoring by Quality Assurance and Performance Improvement (QAPI). Cross reference F602. This citation relates to Intake 2701568. 3.1-25(e)(2) 3.1-25(e)(3) 3.1-25(s)