STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	2027 College Avenue Elk Horn, IA 51531

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** 37074 Based on observations, record review, facility camera footage review, staff interviews, resident interviews and facility policy review the facility failed to ensure 1 of 3 residents (Resident #1) was free from financial exploitation. The facility reported a census of 45 residents. Findings include: According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 7/30/24 documented Resident #1 had a Brief Interview of Mental Status (BIMS) score of 15. A BIMS score of 15 suggested no cognitive impairment. The MDS documented the following diagnoses for Resident #1: atrial fibrillation, diabetes mellitus, depression, spinal stenosis, pulmonary hypertension, sleep apnea, proteinuria, long term use of insulin, and morbid obesity. The Care Plan had the following focus areas: Resident #1 was on diabetic therapy (initiated 7/11/24), the resident has diabetes mellitus (initiated 7/11/24), and had a potential nutritional problem related to the diagnoses of morbid obesity, type 2 diabetes mellitus, depression, and GERD (initiated 7/26/24). On 10/15/24 at 3:19 PM observed Staff H Licensed Practical Nurse (LPN) retrieve Resident #1's Ozempic pen box from the medication room. The box was sealed closed to indicate it had not been opened yet. The box is white with the left top and bottom corners to be red in color. Resident #1's name was printed on the prescription sticker and indicated it contained one pen for three injections. When view the side of the box, a picture of the pen is shown. The pen and pen cap are light blue in color with the center of the pen containing a white medication label. The following Progress Notes were documented for Resident #1: a) On 9/13/24 at 8:38 AM resident aware her Ozempic Pen-injector needs to be ordered. b) On 9/14/24 at 12:12 PM someone in the business office informed this nurse pharmacy is not sending Ozempic injection for Resident #1 that was due yesterday (9/13/24). Given paper where pharmacy delivered a quantity of 3 on 9/7/24. No staff signature noted. This nurse and staff nurse in the building looked on Center and [NAME] halls, injector pen was not located. (continued on next page)

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
	165155	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	2027 College Avenue Elk Horn, IA 51531

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	c) On 9/16/24 at 3:03 PM a facsimile (fax) was sent to Resident #1's primary care provider (PCP) that resident was unable to get her 9/13/24 dose of Ozempic and that pharmacy will be sending one today. When available the dose will be given upon arrival. The Treatment Administration Record (TAR) will be changed to be administered weekly on Mondays. d) On 9/16/24 at 3:04 PM the pharmacy was contacted and will send out Resident #1's Ozempic today. Review of a Pharmacy Facility Delivery Log with a delivered date of 9/7/24 listed Resident #1's Ozempic injector pen was delivered to the facility. Staff I Agency Licensed Practical Nurse (LPN) signed the form as receiving the medication. The August 2024 TAR contained the following orders: a) Ozempic (0.25 or 0.5 milligram (MG)/DOSE) Subcutaneous Solution Pen-injector 2MG/3 (milliliter) ML (Semaglutide) Inject 0.5 mg subcutaneous one time a day every Friday related to type 2 diabetes mellitus. The order was documented to be given during the morning medication pass; between 7:00 AM and 9:00 AM. The order was signed out as being given on 8/16/24, 8/23/24, and 8/30/24. The September 2024 TAR contained the following orders: a) Ozempic (0.25 or 0.5mg/dose) Subcutaneous Solution Pen-injector 2MG/3ML (Semaglutide) Inject 0.5 mg subcutaneous one time a day every Friday related to type 2 diabetes mellitus with a start date of 9/06/2024 and discontinued date of 09/16/2024. The order was documented to be given during the morning medication pass between 7:00 AM and 9:00 AM. The order was signed out as being given on 9/6/24 and on 9/13/24 Staff B Licensed Practical Nurse (LPN) documented see nurse's note. b) Ozempic (0.25 or 0.5mg/DOSE) Subcutaneous Solution Pen-injector 2MG/3ML (Semaglutide) Inject 0.5 mg subcutaneous one time a day every Monday related to type 2 diabetes mellitus with a start date of 9/23/24. The order was signed out as being given on 9/23/24 and 9/30/24 by Staff C RN. The facility provided a paper that documented Resident #1's Ozempic pen had a co-pay cost of $1097.88. The Staffing Agency interview of Staff D dated 10/11/24 at 2:05 PM revealed the following: Staff D reported no issues during the shift as she worked with another Certified Nursing Assistant (CNA). Staff D stated she restocked the carts with insulin, as advised by the charge nurse; this included Ozempic that she received from the refrigerator. Staff D acknowledged she put them all in her pocket because she had other things in her hands. She completed a glucose check and gave residents their insulin's then put the Ozempic pen in the medication cart. Staff D indicated when she left her shift, it was in the medication cart. The off going nurse told her to restock the insulin's as they were low. When the same nurse came in the next day, Staff D advised that she had restocked the medication cart with the insulin's. On 10/16/24 at 2:16 PM the facility's camera footage was reviewed with the Human Resources Director. The footage reviewed on 9/8/24 revealed the following of Staff D Agency Registered Nurse (RN): (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	2027 College Avenue Elk Horn, IA 51531

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	-9:25:06 PM entered the medication room and propped the door open. She brought in a laptop with her. -9:26:45 PM removed one insulin pen from a large green box. -9:27:03 PM removed a 2nd box, put it back and took 1 light blue pen from a red/white box. -9:27:23 PM put the red/white box back in the refrigerator. -9:27:30 PM put the pens in her left scrub top pocket. -9:27:31 PM looked up at the camera. -9:27:32 PM removed the pens from her pocket. -9:27:58 PM put two pens on top of the medication cart, removed one insulin pen from the medication cart and placed it on top of the medication cart. -9:29:30 PM puts a light blue pen in her left scrub top pocket. -9:30 PM-9:32 PM goes to Resident #9's room. -9:32:56 PM stopped to the right of Resident #1's room, leaning on the hand rails. Does not enter Resident #1's room. On 10/15/24 at 3:23 PM Staff H stated she worked the day Resident #1's Ozempic pen was delivered on 9/7/24. Staff I Agency LPN signed for the pen then brought it down to her to be stored in the medication room. Staff H stated she then put the pen in the medication room's refrigerator. The box it came in was sealed, not opened when she placed it in the refrigerator. She reported there was only one pen in the box and it comes with another box that contains the needle caps that go on the pens for administration. There are 6 needle caps with each box delivered. She verified it was the same box observed by the surveyor with her present. Staff H vaguely remembers Staff D but knows they do not restock insulin's during the overnight shift, she would not have asked her to do that. She stated nurses will replace the insulin pens once they are empty. Staff H also stated they do not keep Ozempic pens in the medication cart because it is only given weekly. Staff H stated prior to the pen missing they would store them on the second shelf in the medication room refrigerator. Since this incident, they now store them in a lock box on the counter, counted and recorded at each shift change. When asked who has access to the medication room where the pens are stored, she stated only the nurses. On 10/16/24 at 11:37 AM Resident #1 was sitting in her room in her recliner. She stated she receives her Ozempic injections once a week and she is finally feeling better since starting it. Resident #1 indicated when she first started the medication she was not feeling well; nausea, vomiting, and stomachs. She acknowledged the facility had to push one of her doses back a few days because someone had stolen the pen. Since then they have it back on schedule but on a different day. Resident #1 stated she was unsure who took the pen but reported the facility replaced the pen for her. Resident #1 denies having issues with delays in her injections since that pen was stolen. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	2027 College Avenue Elk Horn, IA 51531

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	On 10/16/24 at 12:18 PM Staff C stated she did not see the Ozempic pen in the medication cart nor do they store it in the medication cart. She also indicated the nurses do not restock the medication carts with insulin pens. The insulin pens and Ozempic pen are stored in the medication room refrigerator. On 10/18/24 at 10:56 AM Staff D RN stated she worked at the facility one overnight shift through an agency. Staff D stated she only worked one shift because apparently there was an Ozempic pen that was missing and the facility alleged she took it. When asked how the facility determined that she stated she was in the medication room to get the insulin pens and Ozempic pen. They told her they saw her on video removing the Ozempic pen from the medication room refrigerator. The night she worked the nurse she relieved had asked her to restock the insulin's in the medication cart for the hall she was working on. She acknowledged she removed the Ozempic pen from the box in the refrigerator located in the medication room. She noted several insulin pens needed to be restocked that night and she needed one of the insulin's so she got that one out of the refrigerator. Staff D indicated they store the Ozempic pen in the medication cart and that the off going nurse stated that pen needed to be in the medication cart. Staff D indicated the overnight nurse was responsible for stocking the medication carts. When asked what happened to the Ozempic pen, she stated she remembered she completed a blood sugar check but not sure what exactly happened to it. She stated she did not take it, thought maybe she set it down somewhere and did not pick it up. She also thought maybe when one the insulin pens was empty maybe she accidentally discarded the Ozempic pen in the sharps container. Staff D then stated she can't take Ozempic because it throws her Rheumatoid Arthritis in to a flare up. She added she had her own prescription back in June but had to stop because of the side effects. Staff D also stated she had no desire or reason to take the stupid pen and if the facility had talked to her about it, she would have reimbursed the cost of the pen. On 10/22/24 at 11:56 AM the Administrator stated the DON had called her on a Sunday to report the Ozempic pen was missing. They knew the pen was delivered to the facility on [DATE] so they started to watch the video footage from that date. As they watched the footage they saw Staff D handled the Ozempic pen. This was the first and only shift Staff D had worked at the facility. They had a call in and Staff D came in to cover that shift. On 10/22/24 at 12:29 PM the DON stated as soon as she was made aware of the Ozempic pen missing, she went looking for it. She looked in all the medication carts, the resident's room, everywhere she could think of. When called the pharmacy to let them know they could not find it. They told her that if they found it, it could stay out of the refrigerator for 56 days. The Health Information Manager and herself looked in the sharps container of the medication carts and it was not in there. The HR Director and the Administrator came and got her so she could see what they saw on the camera footage. She could not believe that she saw Staff D handling and putting the Ozempic pen in her pocket. The DON stated there was no reason Staff D should have handled the Ozempic pen that night because it's only administered weekly. Review of the facility's Abuse and Neglect policy with a revision date of 7/22/24 documented residents have the right to be free from misappropriation of resident property.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	2027 College Avenue Elk Horn, IA 51531

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 37074 Based on record review, facility investigative file, staff interviews, resident interviews and facility policy review the facility failed to ensure staff followed professional standards while administering medications for 4 of 4 residents reviewed (Resident #3, #4, #5, and #6). The facility reported a census of 45 residents. Findings include: 1. According to the significant change Minimum Data Set (MDS) assessment tool with a reference date of 9/16/24 Resident #3 had a Brief Interview of Mental Status (MDS) score of 14. A BIMS score of 14 suggested no cognitive impairment. On 10/16/24 at 11:30 AM Resident #3 was sitting in her recliner in her room listening to an audiobook with her oxygen on via nasal cannula from an oxygen concentrator. When asked if she felt her medications were being given as ordered she stated oh gosh yes, at least she thought. She added she has to be careful because she takes a lot of pills because of her heart failure. She had recent been to the hospital because she was short of breath and found to have a lot of fluid around her heart. She is feeling much better now and they had to since increase her oxygen requirements. 2. According to the annual MDS assessment tool with a reference date of 8/9/24, Resident #4 had BIMS score of 14. A BIMS score of 14 suggested no cognitive impairment. On 10/16/24 at 11:25 AM resident was lying in bed in her room. When asked if she receives her medications as ordered, she stated there was an incident recently. She was getting her bath and realized she had not received her medications. She asked Staff A Registered Nurse (RN) where her medications were. Staff A reported to her he put them on her bedside table, but when she returned to her room she stated they were not on the table. When he brought her medications in after she told him that, he only brought in her blood pressure medication. She added she counts her pills and knew she had more than one pill. Resident #4 stated Staff A knows pharmacy sends extra pills, so she could have received all of her pills that day. When asked how long ago this happened, she stated about two weeks ago. 3. According to the annual MDS assessment tool with a reference date of 9/17/24, Resident #5 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. On 10/16/24 at 2:41 PM Resident #5 stated she receives her medications most of the time. When asked to elaborate on that, she stated Staff A did not give her all of her medications one day and gave her clonazepam late. She indicated this happened about 3-4 weeks ago. Another nurse came on and noticed this, then it was given to her. Resident #5 reported that only happened once but she has heard other residents having issues with not getting their medications. When asked which residents have complaint, she could not remember their names. 4. According to the quarterly MDS assessment tool with a reference date of 7/18/24, Resident #6 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	2027 College Avenue Elk Horn, IA 51531

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/17/24 at 9:05 AM Resident #6 stated she sometimes does not receive all of her medications. When asked how Staff A was with getting her medications for her, she stated bad. When asked what was going on for her to say that, she stated they are supposed to take her pulse right when she gets up because of her pacemaker. The doctor wants her pulse measured before she starts her day which is usually about 6:30 AM. But when Staff A is working, he would not check her pulse until after 1:30 PM which is usually after she rides the bike in therapy. At that time, it's not an accurate reading because she has been up and moving all day. After he takes her pulse, he then administers her medications, which is usually about 2:00 PM. When asked if she gets her medications in the morning, she indicated no. She added Staff A would give all of her medications at that time; about 2:00 PM. The facility's investigation file contained the following summary of events: -On 9/26/24 at 4:58 AM a message from the overnight shift nurse that she had found multiple pills in the sharps container. She reported that on 9/25/24 the sharps container was emptied before end of shift around 6:40 AM. Investigation on pills still going, but was able to narrow down a shift and nurse working this shift. The overnight shift nurse also reported that on 9/25/24 an extra pill was found in a pill package for one resident that was not given, the narcotic count was off, but was able to administer that medication. -On 9/26/24 at 1:30 PM the Director of Nursing (DON), Administrator and Human Resource Director called and spoke to Staff A. He stated that he was questioning why he works here because he felt frustrated being put on a side that he had not worked on. When asked why he didn't ask for help, he stated he didn't know, he didn't think about that. Staff A stated that he did not get any complaints, that he did not give anyone the wrong medications and did not forget any medications besides a Clonazepam. When the Staff E RN and him were doing count, they noticed that it was off. Both nurses went to ask if she wanted it, resident refused, and Staff A stated he did not know where the Clonazepam went, as he has never wasted medications at this facility before. The DON gave him education on the process of wasting medications (2 signatures of 2 nurses for narcotics and place in the drug buster) and that medications cannot go into the trash can. Staff A acknowledged he has thrown medications into the sharps container. On Wednesday 09/25/24 he threw a cup full away due to them falling on the floor (in the sharps container). When asked how many he stated maybe 8 and for a resident but not 100% sure. Staff A thought it happened around the morning medication pass. Staff A was told that because this was under investigation that he will be on suspension pending investigation, and he said that's fine. The facility was able to identify 16 resident's medications that were located in the sharps container. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	2027 College Avenue Elk Horn, IA 51531

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/16/24 at 1:09 PM Staff E Registered Nurse (RN) stated she had followed Staff A RN for the second day in a row and residents were complaining about not receiving their medication when he was working. She stated Resident #5, #6, #9, and #10 were a few residents that had stated they were not receiving their medications. Staff E stated she worked the night before residents were complaining about that. It was part of her routine to check the sharps container on her medication cart and replace it if it was full. That night it was full, she changed it out with an empty sharps container. She came in the following day for her next shift, Staff A had worked the first shift. She noticed the sharps container was full and saw there were pills in it. Staff E stated she dumped the container out, then sent a text to the DON at about 3:00 AM-4:00 AM to let her know what she had found. The DON let her know she would investigate it when she gets to the facility. She had sent her a text back after 6:30 AM. When asked why she stated sting during her interview with the facility, she stated she was a little frustrated because the DON was not responding to her messages about what was found and Staff A was over an hour late to his shift, which meant she could not leave. She acknowledged she was being sassy when the facility was asking her questions about finding the pills in the sharps container. Staff E indicated on that same day when she first got to the facility, Resident #5 was talking to Staff A, telling him she did not feel well. She indicated her and Staff A were completing their narcotic count and she noticed Resident #5's clonazepam was still in the medication cassette. It was signed out on the MAR and the count sheet as being given. Staff A ended up administering the medication to Resident #5. Staff E stated she does not put medications in the sharps container unless it's over the counter medications. On 10/16/24 at 1:33 PM Staff F Certified Medication Aide (CMA) stated Staff E was stocking the medication cart, which she does every night to make sure everything is full and ready for the next shift. Staff E would always check the sharps container too because it seemed to be full a lot. Staff F indicated she worked the night shift on the morning Staff E found the pills in the sharps container. When Staff E held up the sharps container, there was not just a couple of pills in there, there was a lot which was very unusual. Staff E took everything out and put all the pills in a plastic bag. Staff E started to take notes, sent a text to the DON. When asked if any residents made comments to her about not receiving their medications, Staff F stated there were quiet a few complaining they did not think they received their medications. She over heard Resident #5, #6, and #10. Staff F added this was not the first time she had heard residents complaining about not getting their medications. When asked how long this had been going on she guessed maybe a week or two. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165155	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Lutheran Home	2027 College Avenue Elk Horn, IA 51531

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/17/24 at 10:11 AM Staff G Agency LPN stated she was working on the opposite side of the facility the night Staff E found the pills in the sharps container. Staff E told her at the first part of their shift that a lot of residents were complaining about not getting their medications. Later that same shift Staff E brought over some papers needed to get printed and told her she found a lot of pills in the sharps container. Staff G told Staff E that it was weird they were in there and questioned when the sharps container was changed out. Staff E told her she just changed it out. Staff G went on about getting her tasks completed when at about 4:00 AM, she got a message on her walkie talkie asking her to come to look at something. Staff G told Staff E she needed to finish assisting a resident and she would be over. When she went to where Staff E was working, she was standing in front of the medication cart and Staff F was standing in the doorway. Staff G noticed the top of the medication cart was full of all kinds of pills, off to the side was an empty sharps container. Staff G was taken back by this and was able to identify a few medications as an antibiotic, gabapentin, and a buspar that Resident #3 takes. That pill stood out to her because it's odd shaped. Staff G went and got a baggie for Staff E to put the pills in then Staff G went back to work. At about 5:00 AM Staff E brought over a yellow envelope to put in the locked medication room and let her know the DON would pick it up when she arrived at work. She had a feeling that he did not like to do his medication pass because is was not one to move too quickly when starting his tasks while in training. Staff G added a lot of residents know how many pills they get, what they take and when they take them. On 10/22/24 at 9:50 AM an attempt to contact Staff A was made. Staff A did not answer his phone, a voicemail was left and a text message was sent. At the conclusion of the investigation, no return call was received. On 10/22/24 at 11:56 the Administrator stated they provided education to staff on not using the sharps container when disposing of medications. During their interview with Staff A he stated he thought he dropped 8 pills and put them in the sharps container and he knew about Resident #5 not getting her Clonazepam but Staff E gave it once they noticed it was not given. When she told him, they found 41 pills in the sharps container, he stated oh wow that's a lot. The Administrator stated there were morning, afternoon, evening and bedtime medications in the sharps container. Staff E did acknowledge she put over the counter medications in the sharps container. On 10/22/24 at 12:29 PM the DON stated she received a picture on her cell phone from Staff E of all the pills that were found in a sharps container. Staff E also left her a voicemail. Staff E stated in a nutshell, there were residents complaining that Staff A was not giving them their medications so she set something up to catch him. Once in the building the DON assessed all the residents on that hall, interviewed them and staff members. They reviewed camera footage as well and it appeared Staff A administered medications but with some of the camera angles it was hard to tell if he was or wasn't giving residents their medications. When they went through the pills and the MARs, they were able to identify most of the pills were Resident #3's. They could not figure out why some of the medications were given but others were in the sharps container. The facility provided a document titled Medication: Administration Including Scheduling and Medication Aides, with a revision date of 5/21/24. The purpose of this policy was to administer medications correctly and in a timely manner.