

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235287	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/09/2025
NAME OF PROVIDER OR SUPPLIER  Adrian Bay Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  700 Lakeshire Trail Adrian, MI 49221	

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 0609  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.  (continued on next page)

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intakes 2677539 and 2677568. Based on observation, interview and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for two (R3 and R7) of seven reviewed. Findings Include: Resident #3 (R3) Review of the medical record reflected R3 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included sepsis, osteoarthritis, low back pain and spinal stenosis. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/2/25, reflected R3 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/8/25 at 9:40 AM, R3 was observed in bed and reported taking Norco (opioid/controlled pain medication) as needed. R3 reported there had been a nurse that documented administering Norco to her two times in one day/shift, but she did not receive the medication either time. R3 reported requesting pain medication after wound care and being told by the nurse that it was too soon to have a dose, due to documentation which reflected she received it at 4:00 AM. R3 reported not receiving Norco on another occasion and could not recall the date. Resident #7 (R7) Review of the medical record reflected R7 admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included muscle wasting and atrophy, malignant neoplasm (cancerous tumor) of unspecified part of bronchus or lung and fracture of the sacrum. The Quarterly MDS, with an ARD of 6/5/25, reflected R7 scored 11 out of 15 on the BIMS. R7 discharged from the facility on 6/28/25. A Witness Statement for R3, dated 11/18/25 at 2:45 PM, reflected R3 reported a nurse marked down that she took Norco (opioid/controlled pain medication), but she did not get it. R3 reported asking Licensed Practical Nurse (LPN) C if her Norco was marked down (as administered) and was told that it was. R3 stated she knew she did not receive it. R3 reported her pain was not usually too bad, but she had a treatment on her buttocks that day and had level ten out of ten pain on her right side. A Witness Statement for LPN C, dated 11/18/25 at 3:02 PM, reflected R3 asked LPN C to see if her Norco was signed out the night prior. LPN C informed R3 it was signed and the time it was signed out for. According to the Witness Statement, LPN C reported in May (2025) that a nurse was (allegedly) not giving narcotic (controlled medication) that was signed out and was (allegedly) forging signatures. The Witness Statement reflected LPN C reported it to their direct supervisors. A Witness Statement for Registered Nurse (RN) G, dated 11/18/25 at 3:47 PM, reflected R3 requested pain medication the night prior, around 10:00 PM. RN G could not recall if R3 received pain medication that morning. When asked if she gave R3 one or two doses of pain medication on her shift (11/17/25 to 11/18/25), RN G stated just one but could not remember. R3's Controlled Drug Record reflected doses of one tablet of hydrocodone-acetaminophen (Norco) 5/325 milligrams were signed out of the medication cart on 11/17/25 at 9:00 PM and on 11/18/25 at 4:30 AM, with RN G's signature. The November 2025 MAR reflected a dose was documented as administered by RN G on 11/17/25 at 8:52 PM. The dose signed out of the Controlled Drug Record on 11/18/25 at 4:30 AM was not documented on the MAR as being administered to R3. A Witness Statement from LPN C for 11/26/25 reflected she alleged forged signatures ongoing since May (2025), which she first noticed on 5/20/25, pertaining to R7's oxycodone (opioid/controlled pain medication). According to the statement, LPN C alleged since then, there had been several other instances, which had been reported to Director of Nursing (DON) B. The statement reflected LPN C reported discrepancies with her signature for 3/30/25, 5/5/25 and 11/17/25. An investigation binder, provided by the facility, reflected daily timecard punches for LPN C for 5/1/25 to 6/1/25, as well as Controlled Drug Records for residents, which had LPN C's signatures highlighted. LPN C's signatures for May 2025 had notation of work and eMAR (Electronic Medication Administration Record) beside them. In a phone interview on 12/8/25 at 10:17 AM, LPN C reported suspicion of their signature being forged to sign out controlled medications, which Nursing Home Administrator (NHA) A had been made aware of on 11/18/25. LPN C reported controlled medications were being signed out on the Controlled Drug Record but not the MAR and reported suspicion that her signature had been forged for oxycodone on 3/30/25, 5/5/25 and 5/21/25 and for Norco on 11/17/25. In an interview on 12/8/25 at 12:08 PM, LPN E reported being aware that LPN C had concerns pertaining to controlled medications being signed out but not being received by residents in the prior two to three weeks. LPN E reported the DON was aware, and an investigation had been started. LPN E stated LPN C had also made a previous complaint, in April or May of 2025, pertaining to not believing a signature (on a Controlled Drug Record) was hers. LPN E stated that was reported to the</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intakes 2677539 and 2677568. Based on observation, interview, and record review, the facility failed to administer medications according to the physician's order for two (R4 and R5) of five reviewed. Findings include: Resident #4 (R4)</p> <p>Review of the medical record revealed R4 was admitted to the facility on [DATE] with diagnoses that include polyneuropathy (disease affecting nerves) and low back pain. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/28/25 revealed R4 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>On 12/8/25 at 11:02 AM, R4 was observed sitting in her wheelchair in the dining room. R4 reported she takes Norco (hydrocodone-acetaminophen 5-325 milligrams (mg)/controlled opioid pain medication) every six hours as needed for pain.</p> <p>Review of the Physician's Order dated 10/13/25 revealed an order for hydrocodone-acetaminophen 5-325 mg give one tablet every six hours as needed for pain management.</p> <p>Review of the Controlled Drug Record revealed doses were signed out at a frequency greater than every 6 hours on 10/26/25 at 6:00 PM and 7:40 PM, 10/30/25 at 6:00 PM and 8:00 PM, 11/8/25 at 12:00 PM and 1:00 PM, 11/9/25 at 6:00 PM and 8:30 PM, and 11/13/25 at 6:00 PM and 11:00 PM. Of these doses, the Medication Administration Record (MAR) did not reflect documentation on 10/26/25 at 6:00 PM, 10/30/25 at 6:00 PM, 11/8/25 at 12:00 PM and 1:00 PM, 11/9/25 6:00 PM, and 11/13/25 at 6:00 PM.</p> <p>Resident #5 (R5):</p> <p>Review of the medical record reflected R5 admitted to the facility on [DATE], with diagnoses that included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease and type 2 diabetes mellitus with diabetic neuropathy. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/13/25, reflected R5 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>On 12/8/25 at 11:29 AM, R5 was observed sitting on the edge of their bed. R5 acknowledged taking pain medication, stating they had requested some that morning.</p> <p>R5's November 2025 Medication Administration Record (MAR) reflected a Physician's Order for oxycodone hydrochloride (HCl) (opioid/controlled pain medication) five milligrams (mg) by mouth, every six hours, as needed, for moderate to severe pain. According to the MAR, the medication was signed out as administered on 11/9/25 at 7:17 AM and 8:37 PM. There were no further doses signed out as administered on the MAR for 11/9/25.</p> <p>According to R5's oxycodone HCl five mg Controlled Drug Record, five total doses of the medication were signed out on 11/9/25. The documented times, in order, reflected 4:00 AM, an illegible time, 1:00 PM, 8:40 PM and an additional illegible time.</p> <p>According to R5's November MAR and the oxycodone HCl five mg Controlled Drug Record, R5's doses were signed out at a frequency of less than every six hours on 11/9/25.</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The November 2025 MAR reflected oxycodone HCl five mg by mouth, every six hours, as needed, for moderate to severe pain was signed out as administered on 11/13/25 at 8:45 PM. There were no further doses signed out as administered on the MAR for 11/13/25.</p> <p>According to R5's oxycodone HCl five mg Controlled Drug Record, two doses of the medication were signed out on 11/13/25. One dose was signed out at 4:45 PM and one dose at 9:00 PM, which was less than six hours apart.</p> <p>R5's December 2025 MAR reflected oxycodone HCl five mg by mouth, every six hours, as needed, for moderate to severe pain was signed out as administered on 12/4/25 at 6:06 PM. There were no further doses signed out as administered on the MAR for 12/4/25.</p> <p>According to R5's oxycodone HCl five mg Controlled Drug Record, doses of the medication were signed out less than two hours apart on 12/4/25. One dose was signed out at 6:06 PM and an additional at 8:00 PM.</p> <p>In a phone interview on 12/8/25 at 3:31 PM, when asked if they knew why there could be discrepancies between documentation on MARs and Proof of Use sheets (Controlled Drug Records), Registered Nurse (RN) G indicated there was so much to do and so much going on that they were forgetting (to document in both places). Regarding timing of as needed medication administration, RN G reported the MAR would indicate if the medication was able to be given and would not allow a nurse to sign a medication out before a resident could have the next dose.</p> <p>In an interview on 12/9/25 at 9:45 AM, Director of Nursing (DON) B reported the expectation for signing out controlled medications was to look at the log, as the Proof of Use sheet was the most accurate form of documentation. DON B reported nurses should have been signing out controlled medications on the Proof of Use sheet and the MAR. DON B agreed that R4 and R5 had doses of controlled medications that had been administered too close together based on the time parameters in the Physician's Orders.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intakes 2677539 and 2677568. Based on observation, interview, and record review, the facility failed to maintain accurate controlled substance and medication administration records for five residents (R1, R3, R4, R5, R6) of six reviewed and two medication carts of two reviewed. Findings include: During an observation and interview with Licensed Practical Nurse (LPN) M, on 12/8/25 at 10:37 AM, it was noted that the controlled substance book indicated 45 controlled medications were in the medication cart. Upon count of the total number of medications, it was observed that 44 controlled medications were in the medication cart. LPN M counted the total amount of medications a second time and was initially unable to explain the discrepancy. LPN M then reported one medication had been removed from the medication cart, after the last dose was administered that morning. LPN M obtained the Controlled Drug Record from the facility's mail room, which noted the last dose of the controlled medication was signed out on 12/8/25 at 7:15 AM.</p> <p>During count of the individual controlled medications in the medication cart, with LPN M, it was observed that R1's Controlled Drug Record for Morphine Concentrate 100 milligrams (mg) per five milliliters (mL) noted 17 mL remained in the bottle. Observation revealed that more than 20 mL remained in the bottle. When asked how much was in the bottle, LPN M reported the amount to be approximately 23 mL. It was noted that the last entry on the Controlled Drug Record was 11/30/25.</p> <p>LPN M reported the process for counting controlled medications was for the off-going nurse to read the count from the controlled substance book, while the on-coming nurse verified the count of each medication. LPN M reported the total amount of controlled medications was verified first, followed by count of the individual controlled medications. When removing controlled medications from the medication cart, LPN M reported they noted medication on the Controlled Drug Record but did not record the time until they knew the resident was taking it.</p> <p>In an interview on 12/8/25 at 12:08 PM, LPN E reported controlled medications were to be signed out after they were administered, in case the resident refused. According to LPN E, the process was to pull the medication (from the package), flag the Controlled Drug Record, then sign the medication out on the Medication Administration Record (MAR) and Controlled Drug Record (after the medication was administered).</p> <p>In an interview on 12/8/25 at 1:43 PM, Director of Nursing (DON) B reported she was to be contacted if there was a discrepancy with controlled medication count. DON B reported counting controlled medications that day, and R1's Morphine count was over. The Controlled Drug Record reflected 17 mL was in the bottle, however, there was approximately 23 mL remaining, according to DON B.</p> <p>Resident #1 (R1)</p> <p>Review of the medical record reflected R1 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included sepsis, chronic pain, muscle spasm and malignant neoplasm (cancerous tumor) of overlapping sites of the lip, oral cavity and pharynx. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/26/25, reflected R1 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R1 was observed in the hallway on 12/8/25 at 11:57 AM and declined to be interviewed.</p> <p>R1's November 2025 and December 2025 Medication Administration Records (MARs) reflected a Physician's Order for Percocet (oxycodone-acetaminophen) 10/325 mg by mouth, every four hours, as needed, for pain.</p> <p>Review of the MARs and the Controlled Drug Records reflected the following discrepancies:</p> <p>On 11/1/25 at 9:00 AM, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R1.</p> <p>On 11/2/25, at an illegible time, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R1 for that date.</p> <p>On 11/4/25, at 4:00 AM, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R1.</p> <p>On 11/6/25, at 12:30 PM, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R1.</p> <p>On 11/6/25, at 5:00 PM, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R1.</p> <p>On 11/6/25, at 9:00 PM, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was signed on the MAR as administered to R1 at 8:06 PM.</p> <p>On 11/7/25, at 5:00 AM, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was signed on the MAR as administered to R1 at 5:53 AM.</p> <p>On 11/14/25, at 12:30 PM, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R1.</p> <p>On 11/17/25, at 9:00 PM, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R1.</p> <p>On 11/18/25, at 5:00 AM, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R1.</p> <p>On 11/20/25, at 9:00 PM, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R1.</p> <p>On 11/22/25, at 2:43 PM, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R1.</p> <p>On 12/1/25, at an illegible time, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R1 for that date.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/6/25, at 1:10 PM, oxycodone-acetaminophen 10/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R1 for that date.</p> <p>Resident #3 (R3)</p> <p>Review of the medical record reflected R3 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included sepsis, osteoarthritis, low back pain and spinal stenosis. The Quarterly MDS, with an ARD of 11/2/25, reflected R3 scored 15 out of 15 (cognitively intact) on the BIMS.</p> <p>On 12/8/25 at 9:40 AM, R3 was observed in bed and reported taking Norco (opioid/controlled pain medication) as needed. R3 reported there had been a nurse that documented administering Norco to her two times in one day/shift, but she did not receive the medication either time. R3 reported requesting pain medication after wound care and being told by the nurse that it was too soon to have a dose, due to documentation which reflected she received it at 4:00 AM. R3 reported not receiving Norco on another occasion and could not recall the date.</p> <p>R3's November 2025 and December 2025 MARs reflected a Physician's Order for Hydrocodone-Acetaminophen 5/325 mg by mouth, every four hours, as needed, for pain.</p> <p>Review of the MARs and the Controlled Drug Records reflected the following discrepancies:</p> <p>On 11/4/25 at 3:30 AM, hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was signed out on the MAR as administered to R3 at 4:48 AM.</p> <p>On 11/4/25, at an illegible time (possibly 8:00 PM or 9:00 PM), hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R3.</p> <p>On 11/6/25 at 1:00 PM, hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was signed out on the MAR as administered to R3 at 2:45 PM.</p> <p>On 11/6/25 at 5:00 PM, hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R3.</p> <p>On 11/7/25 at 1:38 PM, hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R3.</p> <p>On 11/7/25 at 9:00 PM, hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R3.</p> <p>On 11/11/25 at 9:00 PM, hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R3.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/14/25 at 8:00 AM, hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R3 for that date.</p> <p>On 11/14/25 at 1:30 PM, hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R3 for that date.</p> <p>On 11/16/25 at 9:00 PM, hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R3 for that date.</p> <p>On 11/17/25 at 1:10 PM, hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R3.</p> <p>On 11/18/25 at 4:30 AM, hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R3.</p> <p>On 11/21/25 at 8:00 AM, hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R3.</p> <p>On 11/27/25 at 2:42 PM, hydrocodone-acetaminophen 5/325 mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R3 for that date.</p> <p>Resident #5 (R5):</p> <p>Review of the medical record reflected R5 admitted to the facility on [DATE], with diagnoses that included acute respiratory failure with hypoxia, chronic obstructive pulmonary disease and type 2 diabetes mellitus with diabetic neuropathy. The admission MDS, with an ARD of 10/13/25, reflected R5 scored 15 out of 15 (cognitively intact) on the BIMS.</p> <p>On 12/8/25 at 11:29 AM, R5 was observed sitting on the edge of their bed. R5 acknowledged taking pain medication, stating they had requested some that morning.</p> <p>R5's November 2025 and December 2025 MAR reflected a Physician's Order for oxycodone hydrochloride (HCl) five mg by mouth, every six hours, as needed, for moderate to severe pain.</p> <p>Review of the MARs and the Controlled Drug Records reflected the following discrepancies:</p> <p>On 11/5/25 at 9:00 PM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5.</p> <p>On 11/7/25 at 7:00 PM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5.</p> <p>On 11/8/25, at an illegible time, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Adrian Bay Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  700 Lakeshire Trail Adrian, MI 49221	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/8/25 at 10:00 PM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5.</p> <p>On 11/9/25 at 4:00 AM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5.</p> <p>On 11/9/25 at 1:00 PM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5.</p> <p>On 11/9/25, at an illegible time, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5.</p> <p>On 11/12/25 at 5:30 AM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5 for that date.</p> <p>On 11/12/25 at 12:30 PM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5 for that date.</p> <p>On 11/13/25 at 4:45 PM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5.</p> <p>On 11/14/25 at 5:00 AM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5.</p> <p>On 11/15/25 at 5:15 AM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5 for that date.</p> <p>On 11/15/25 at 8:00 PM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5 for that date.</p> <p>On 11/19/25, at an illegible time (possibly 8:00 PM or 9:00 PM), oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5.</p> <p>On 11/20/25, at an illegible time (possibly 8:00 PM or 9:00 PM), oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5 for that date.</p> <p>On 11/21/25 at 5:00 AM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5 for that date.</p> <p>On 11/23/25 at 4:30 AM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5.</p> <p>On 11/24/25 at 5:00 AM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/2/25 at 5:00 AM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5 for that date.</p> <p>On 12/4/25 at 8:00 PM, oxycodone HCl five mg was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R5.</p> <p>In a phone interview on 12/8/25 at 10:17 AM, LPN C reported suspicion of their signature being forged to sign out controlled medications, which Nursing Home Administrator (NHA) A had been made aware of on 11/18/25. LPN C reported controlled medications were being signed out on the Controlled Drug Record but not the MAR.</p> <p>In an interview on 12/8/25 at 12:08 PM, LPN E reported being aware that LPN C had concerns pertaining to controlled medications being signed out but not being received by residents in the prior two to three weeks. LPN C reported the DON was aware, and an investigation had been started. LPN E stated LPN D also reported a concern for a signature (on a Controlled Drug Record) which they did not believe was theirs. LPN E stated LPN C had also made a previous complaint, in April or May of 2025, pertaining to not believing a signature (on a Controlled Drug Record) was theirs. LPN E stated that was reported to the DON, and they were unsure what happened with that concern.</p> <p>In an interview on 12/8/25 at 1:43 PM, when asked if there had been any controlled medication discrepancies prior to 12/8/25, DON B reported the facility had a thick investigation file because R3 reported not receiving two controlled medications. NHA A was made aware, as she was the facility's abuse coordinator. According to DON B, LPN C stated someone was signing out their name (on the Controlled Drug Record) when they were not in the facility. DON B reported they cross-referenced from May to current on C hall and for the entire month of November. DON B reported they did a full investigation, and LPN C had been working the days the medications were signed out.</p> <p>In a phone interview on 12/9/25 at 12:25 PM, LPN D reported belief that their signature had been forged to sign out Percocet for R1 on 11/20/25. LPN D reported checking the Controlled Drug Record the next time she worked and noticed her signature. LPN D stated R1 had been sleeping, and she knew for a fact she did not give R1 and as needed medication on 11/20/25.</p> <p>R4</p> <p>Review of the medical record revealed R4 was admitted to the facility on [DATE] with diagnoses that include polyneuropathy (disease affecting nerves) and low back pain. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/28/25 revealed R4 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>On 12/8/25 at 11:02 AM, R4 was observed sitting in her wheelchair in the dining room. R4 reported she takes Norco (hydrocodone-acetaminophen 5-325 milligrams (mg)/controlled opioid pain medication) every six hours as needed for pain.</p> <p>Review of the Physician's Order dated 10/13/25 revealed an order for hydrocodone-acetaminophen 5-325 mg give one tablet every six hours as needed for pain management.</p> <p>Review of the Medication Administration Records (MARs) and the Controlled Drug Records revealed the following discrepancies:</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/25/25 at 11:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 10/26/25 at 4:45 AM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 10/26/25 at 12:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 10/26/25 at 6:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 10/29/25 at 12:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 10/29/25 at 6:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 10/30/25 at 12:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 10/30/25 at 6:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 10/31/25 at 3:00 AM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 10/31/25 at 8:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/5/25 at 3:00 AM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/8/25 at 12:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/8/25 at 12:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was signed out on the MAR as administered to R4 at 2:16 PM.</p> <p>On 11/9/25 at 6:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/10/25 at an illegible time (possibly 12:00 AM or 5:00 AM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4 on 3:19 AM.</p> <p>On 11/11/25 at 8:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/12/25 at 7:00 AM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/12/25 at 2:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/12/25 at 9:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/13/25 at 6:00 AM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/13/25 at 6:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/15/25 at an illegible time (possibly 12:00 AM), hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/15/25 at 9:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/19/25 at 9:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/21/25 at 5:15 AM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/22/25 at an illegible time (possibly 8:00 PM or 10:00 PM), hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/22/25 at an illegible time (possibly 8:00 PM), hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/23/25 hydrocodone-acetaminophen was signed out as administered on the MAR at 12:25 AM but not signed out on the Controlled Drug Record until 4:30 AM.</p> <p>On 11/26/25 at 6:00 AM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/27/25 at 8:00 PM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>On 11/28/25 at an illegible time (possibly 8:00 PM or 10:00 PM), hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 11/29/25 at 5:00 AM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record but was not documented on the MAR as administered to R4 until 7:03 AM.</p> <p>On 12/4/25 at 5:30 AM, hydrocodone-acetaminophen was signed out on the Controlled Drug Record as removed from the medication cart but was not signed out on the MAR as administered to R4.</p> <p>R6</p> <p>Review of the medical record revealed R6 was admitted to the facility on [DATE] with a diagnosis of right humerus fracture. Review of the BIMS dated 12/8/25 revealed R6 scored 12 out of 15 (moderate cognitive impairment).</p> <p>Review of the Physician's Order dated 12/4/25 revealed an order for hydrocodone-acetaminophen 5-325 mg every six hours as needed for pain.</p> <p>Review of the MAR revealed on 12/7/25 at 10:10 PM, hydrocodone-acetaminophen was documented as administered to R6 however, the medication was not signed out on the Controlled Drug Record as being removed from the medication cart at that time.</p> <p>Review of the Controlled Drug Record revealed on 12/8/25 at 300 [possibly 3:00 AM], hydrocodone-acetaminophen was signed out as removed from the medication cart. Review of the MAR revealed the medication was not signed out as administered to R6.</p> <p>On 12/8/25 at 11:28 AM, R6 was observed sitting on the edge of her bed with her right arm in a sling. R6 reported she experienced pain when she moved and that the staff gave her Tylenol for her pain. (It should be noted R6 also had an order for Tylenol as needed). R6 reported there was one night a few nights ago when a male nurse gave her Norco. R6 reported she did not like how the Norco made her feel and preferred to take Tylenol. R6 reported she did not take any Norco for the last two nights.</p> <p>An observation on 12/8/25 at 11:07 AM with Registered Nurse (RN) K revealed the controlled substance book indicated 34 controlled medications were in the medication cart. Upon count of the medications, 35 controlled medications were observed in the medication cart. RN K was unable to explain the discrepancy and reported it could have been a counting error when medications were removed and new medications added.</p> <p>In an interview on 12/8/25 at 1:43 PM, Director of Nursing (DON) B reported RN K notified her of the discrepancy noted that day. DON B reported the count should have been 35, but the book revealed 34 total medications. Nursing Home Administrator (NHA) A joined the interview. NHA A and DON B agreed there were discrepancies in R4 and R6's Controlled Drug Records and MARs.</p>		