

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235450	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2026
NAME OF PROVIDER OR SUPPLIER Allendale Nursing and Rehabilitation Community		STREET ADDRESS, CITY, STATE, ZIP CODE 11007 Radcliff Drive Allendale, MI 49401	
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 - Few	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** This citation pertains to intake #3006042Based on interview and record review, the facility failed to have safeguards and systems in place to ensure the proper storage, dispensing, administering, and reconciliation of controlled substances for 1 resident (Resident #3), reviewed for pharmacy services.Findings:Resident #3 (R3) Review of an admission Record revealed R3 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: traumatic brain injury (TBI).Review of R3's Order Summary dated 2/23/26-4/20/26 revealed he was to receive one 10mg methylphenidate (improves cognitive function following a TBI) tablet in the morning and one 5mg methylphenidate tablet at 3:00 PM.Review of the 4/14/26 and 4/15/26 staffing schedule revealed the following nurses provided care for R3:On 4/14/26 Agency Registered Nurse (RN) J worked 1st shift.On 4/14/26 Agency RN K worked 2nd shift.On 4/14/26 RN L worked 3rd shift.On 4/15/26 Licensed Practical Nurse (LPN) M worked 1st shift.The licensed nurses listed above all had background checks that indicated they were eligible to work, and all had valid nursing licenses that were in good standing with Michigan's board of nursingReview of R3's Controlled Substance Proof of Use form utilized from 4/6/26-4/20/26 and R3's April Medication Administration Record (MAR) revealed that on the morning of 4/14/26 RN J dispensed and administered the methylphenidate 10mg as ordered. On the morning of 4/15/26 LPN M dispensed and administered the methylphenidate 10mg as ordered (No other doses of the methylphenidate 10mg should have been dispensed/administered between the morning of 4/14/26 and 4/15/26). R3's Controlled Substance Proof of Use form revealed that between the morning of 4/14/26 and 4/15/26, there were 2 entries which documented the removal of a total of 2 10mg tablets of methylphenidate. The entries included an illegible date and an illegible nurse's signature with a time of 9:00 AM and 10:00AM on 2 separate lines. There was no documentation that the medication had been removed in error and disposed of with a secondary nurse's witness signature.Review of R3's Electronic Medical Record revealed no documentation that the 2 doses of methylphenidate had been administered, there were no one time orders for the administration of the methylphenidate, and there was no rationale/documentation related to the dispensing of the 2 doses of the methylphenidate.Review of the April Medication Administration Record for all residents residing in the facility at that time revealed no documentation that any other resident was prescribed methylphenidate (verification that R3's methylphenidate was not accidentally administered to another resident with the same medication and dose.)Review of the Facility Reported Incident (FRI) submitted on 4/21/26 revealed that be, On 4/21/2026 the Director of Nursing noted: A medication error was completed; however, two doses of Methylphenidate remain unaccounted for and were signed out with an unidentifiable signature.The Administrator was notified of a potential misappropriation of medication for (R3) after a routine audit was conducted and two methylphenidate 10mg tablets were unaccounted for. After conducting staff interviews to determine who's handwriting it was, we were unable to identify the nurse who wrote the medications down on the controlled substance proof of use sheet. Root Cause Analysis: The investigation determined that the discrepancies involving two unaccounted for methylphenidate 10 mg tablets were not the result of a (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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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed medication diversion, intentional misappropriation, or deliberate misplacement. The controlled substance proof of use sheet contained entries that could not be matched to the MAR. The handwriting and signatures on the proof of use sheet could not be identified. All assigned nurses denied documenting or administering medications outside of their assigned responsibilities and denied sharing or leaving medication cart keys unattended. There were no gaps in medication administration in the MAR for (R3), receiving all prescribed doses of the medication. Review of RN J's Staff Interview completed via telephone and dated 4/23/26 (signed 4/24/26) revealed RN J was assigned to (R3) on 4/14/2026. She administered both doses of methylphenidate 10mg and 5mg that day. He has an AM dose and a dose scheduled at 3:00 PM. I gave my keys to (RN K) (as verified via photo) and completed our counts (counting off the number of controlled substances available for each resident). I did not give my keys to anyone else during the shift, I do not do things like that. I do not recognize the handwriting on the proof of use sheet under the name. Review of RN K's Staff Interview completed via telephone and dated 4/23/26 (signed 4/24/26) revealed, I was assigned to (R3) second shift on 4/14/2026. I do not know who's handwriting that is on the controlled substance proof of use sheet. I did not leave my keys anywhere to my knowledge and I was having trouble when I first got to my shift with my (computer system) login. I followed what was on the MAR. Review of RN L's Staff Interview dated 4/23/26 (signed 4/24/226) revealed, I did not notice the signatures on the sheet, although this medication is not one that I typically pass as it is due on first and second shift. I am not sure of who's handwriting that would be, I do not recognize it. I was assigned to (R3) on third shift. Review of LPN M's Staff Interview dated 4/23/26 (signed 4/24/226) revealed, I do not know who's name this is on the controlled proof of use sheet. I did not notice that it showed that the medication was administered three times that day. That is really strange. I was assigned to (R3) on 4/15/2026. During an interview on 6/29/2026 at 9:01 AM, the Nursing Home Administrator (NHA) reported that during a routine audit on Controlled Substance Proof of Use forms (on 4/21/26 per the FRI summary), 2 tablets of R3's methylphenidate 10mg tabs were discovered as dispensed outside of the practitioner's order. The management team and facility staff were unable to determine who dispensed R3's methylphenidate between 4/14/26 and 4/15/26 due to the illegible signature and dates. The NHA reported that based on the Controlled Substance Proof of Use forms, the MAR, and the witness statements, the result of the investigation was inconclusive. The NHA further reported that based on the timeline of events the management team deemed RN K responsible for the following reasons, 1.) she was the only licensed nurse caring for R3 during the time the methylphenidate went missing that had access to the medication cart, 2.) she may have left the medication cart and narcotic lock box keys accessible to other staff/visitors/residents, and/or 3.) she may have had the keys on her person but left the medication cart and narcotic lock box unlocked. Ultimately, the management team felt that she had not followed professional standards of nursing practice and placed her on the do not return list from the contracted agency. The NHA and the Director of Nursing (DON) confirmed that the facility's pharmaceutical services system would be reviewed to prevent any incident such as this from reoccurring. The NHA reported that a review of the process for accurate reconciliation and accounting for all controlled substances, prompt identification of loss or potential diversion of controlled substances, and proper storage of controlled substances to prevent unauthorized access and/or removal of the medications would be completed. The DON reported she would be increasing the monitoring of medication carts (to ensure they were properly locked without availability to the keys), resident MAR's (to ensure accurate documentation of the administration of controlled medications), as well as frequent audits/reconciliation of the Controlled Substance Proof of Use forms (to ensure controlled substances were not diverted, dispensed outside of the ordered times, and/or in excessive doses). The DON reported that the licensed nurses would be immediately educated on properly storing, dispensing, administering, documenting on, and disposing of controlled substances. Unable to contact RN K during onsite survey. Review of the facility policy, Controlled Substances Standards of Practice last reviewed January 2025 revealed, . The Proof-of-Use sheet will be placed in the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication cart Controlled Substance Tracking Binder (narcotic count book) which will be reviewed when change of ownership of the narcotic keys is made, shift to shift or change in assignment. Distribution and Record Keeping in Facility-Nurses removing controlled substance from the narcotic storage require documentation on the Proof-of-Use Sheet the amount removed using a full last name signature. Nurse documentation of inventory balance on Proof-of-Use sheet MUST be made as soon as the controlled substance is removed from the package/cart. Avoid waiting until the end of med pass or end of shift. Once the nurse completes the administration, then the nurse is to document on the MAR (Medication Administration Record) paper record or E (electronic)-MAR electronic record. If PRN (as needed) medication is administered, additional documentation regarding reason, result, time and initials are required. Note: If documentation is not provided on MAR or E-MAR, medication will be considered not given. MAR or E-MAR is record of administration NOT the proof-of use sheet. Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Guidelines for Safe Opioid (Narcotic) Administration and Control: Store all narcotics in a locked, secure cabinet or container (e.g., computerized, locked cabinets are preferred). Maintain a running count of opioids by counting them whenever dispensing them. If you find a discrepancy, correct it and report it immediately. Use a special inventory record each time an opioid is dispensed. Records are often kept electronically and provide an accurate ongoing count of narcotics used, wasted, and remaining. Use the record to document the patient's name, date, time of medication administration, name of medication, and dosage. If the agency keeps a paper record, the nurse dispensing the medication signs the record. A second nurse witnesses disposal of the unused part if a nurse gives only part of a dose of a controlled substance. If paper records are kept, both nurses sign their names on the form. As a nurse, you are responsible for following all legal regulations when administering controlled substances (medications with potential for abuse). Controlled substances must be properly stored to prevent diversion. Violations of the Controlled Substances Act may result in fines, imprisonment, and loss of license. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.		