STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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. Based on record review and interviews during an abbreviated survey (Case #s NY00376223 and NY00377464), the facility did not ensure it established a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and that it determined that drug records were in order and that an account of all controlled drugs was maintained and periodically reconciled. Specifically, (a) the facility did not ensure narcotics were counted by two (2) licensed staff members on the B-side of unit two (2), on 2/23/2025 at the end of the 3:00 PM to 11:00 PM shift. On 2/24/2025, the 7:00 AM - 3:00 PM nurse discovered twenty (20) Oxycontin extended release 10 milligram (extended-release narcotic pain medication) prescribed for Resident #1 were missing. During the facility's investigation it was determined that narcotic counts were not done by the required two (2) nurses. The physician reordered the medication on 2/24/2025 and was received in the facility on 2/25/2025. On 2/25/2025 at 9:00 PM, the medication administration record documented the medication was given, when the controlled medication record did not indicate a pill was administered, and (b) the facility did not document nursing unit narcotics as having been counted by two licensed staff members and signed as appropriate on the facility-provided narcotic record sheets for six (6) of six (6) nursing units. This is evidenced by: The Policy and Procedure titled, Controlled Substance/Narcotic Management Protocol, reviewed 1/2025, documented it was the facility's policy to prescribe, administer, store and destroy all controlled substances within accepted regulations of the responsible governing body. All controlled substances ordered would be ordered in accordance with best practice and regulations. With each administration, the nurse must document the date, time, prior count and post administration count of the remainder of the medication and sign in the controlled substance logbook in addition to the medication administration record. All narcotics would be counted and reconciled at the beginning of every shift with the outgoing and oncoming nurse. Both must sign the controlled substance log attesting to the presence of the narcotic as stated from the previous shift. Any discrepancies in the count must be reported to the unit manager or nursing supervisor immediately. Staff responsible for narcotic administration would not leave the shift until the narcotic count was reconciled. (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
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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	The facility's Lesson Plan for Controlled Substances & Narcotic Count, dated 2/20/2025, documented the objective was to ensure nurses were following the policy and procedure of narcotic handling and narcotic count. The Policy and Procedure, titled Controlled Substances/Narcotic Management Protocol, reviewed 1/2023 was referenced. Lesson Plan procedure documented nurses would count and reconcile all narcotics at the beginning of every shift with the outgoing and oncoming nurse. Both nurses would sign the controlled substance log attesting to the presence of the narcotic as stated from the previous shift. All nurses would follow the count in chronological order from the previous number stated. Any discrepancies in the count must be reported to the unit manager/nursing supervisor immediately. Resident #1: Resident #1 was admitted to the facility with diagnoses of fibromyalgia (long-term condition that involves widespread body pain), chronic pain syndrome (pain that lasts for over 3 months), and anxiety disorder (repeated episodes of sudden feelings of intense anxiety and fear or terror that reach a peak within minutes (panic attack). The Minimum Data Set (an assessment tool) dated 2/18/2025, documented the resident was cognitively intact. The resident was able to make themselves understood and usually understood others. Order Recap Report for order date 2/1/2025 to 4/25/2025, documented an order dated 2/14/2025 for Oxycontin Oral Tablet extended release 12 Hours Abuse-Deterrent 10 milligram (Oxycodone HCl), give one (1) tablet by mouth two (2) times a day for pain for 14 days. The order start date was 2/16/2025 and end date was 2/24/2025. Individual Controlled Medication Record for Resident #1 dated 2/14/2025, documented Oxycontin Oral Tablet 10 milligrams ER, give one (1) tablet by mouth two (2) times a day for pain for 14 days. The last documented administration was on 2/23/2025 at 10:18 PM by Licensed Practical Nurse #1, with 20 pills remaining. Medication Administration Record dated February 2025, documented Oxycontin Oral Tablet extended release 12 Hours Abuse-Deterrent 10 milligram (Oxycodone HCl) was scheduled to be given daily at 9:00 AM and 9:00 PM. The order start date was 2/16/2025 and was discontinued on 2/24/2025 at 8:59 PM. It documented the medication was administered on 2/23/2025 at 9:00 PM by Licensed Practical Nurse #1. Loss of Controlled Substances Report, date of incident 2/24/2025 at 10:00 AM on unit 2. Description documented: Oxycontin ten (10) milligrams extended release, twenty (20) pills discovered missing morning of 2/24/2025. Medication was last administered on 2/23/2025 at 10:18 PM by Licensed Practical Nurse #1. Licensed Practical Nurse #1 was relieved by Licensed Practical Nurse #2. Licensed Practical Nurse #1 stated they counted all narcotics at medication cart while oncoming nurse, Licensed Practical Nurse #2 was present at desk. Licensed Practical Nurse #2 told Licensed Practical Nurse #1 to lock medications back in the medication cart. Licensed Practical Nurse #2 stated they were not present when Licensed Practical Nurse #1 did the count, but did tell them to keep the medications in the lock box in the medication cart. Licensed Practical Nurse #2 stated they never removed medications from the lock box during their shift, as they did not need to administer the oxycontin to the resident on their 11:00 PM to 7:00 AM shift. The 7:00 AM to 3:00 PM nurse on 2/24/2025 discovered the count was off and 20 pills were missing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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	Review of the untitled narcotic count signature sheet by the on-coming and off-going nurse dated 2/23/2025 on unit two (2) (B-side), documented nurse signatures for all three (3) shifts, indicating the narcotic count was done on all shifts. Notice of Disciplinary Actions documented 2/24/2025, documented Licensed Practical Nurse #s 1, 2, and 3 were given a first and final warning for failure to perform narcotic count with two (2) nurses present at the beginning and end of the shift. General Statement dated 2/24/2025 written by the Director of Nursing #1, documented a phone interview with Licensed Practical Nurse #1. The nurse was asked if they counted the narcotics with their relief on 2/23/2025 at 11:00 PM and they stated yes and stated, 'everything was there.' The nurse was informed that a card of 20 pills of oxycodone was missing for Resident #1. Licensed Practical Nurse #1 stated they gave the resident their dose and it (the pill pack) was there when they left. The nurse suggested that pills may have gotten 'mixed up in other meds.' The nurse was asked where the narcotics were when they gave Licensed Practical Nurse #2 the keys and they stated they asked Licensed Practical Nurse #2 where they wanted the narcotics, and they stated the medication cart and Licensed Practical Nurse #1 put them back in the medication cart. Review of a written statement dated 2/25/2025 by Licensed Practical Nurse #1, documented they counted all the narcotics at the medication cart while Licensed Practical Nurse #2 was sitting at the desk. General Statement dated 2/24/2025 written by the Director of Nursing #1, documented a phone interview with Licensed Practical Nurse #2. Licensed Practical Nurse #2 stated Licensed Practical Nurse #1 called them after they (Licensed Practical Nurse #2) left on the morning of 2/24/2025 and told them the count was off. Licensed Practical Nurse #2 was asked if they counted with the 3:00 PM to 11:00 PM nurse (Licensed Practical Nurse #1) before taking the keys and they stated, 'Kind of. I didn't thoroughly count. They told me it was good.' Licensed Practical Nurse #2 stated they told Licensed Practical Nurse #1 to leave the narcotics in the medication cart and stated they administered narcotics on their shift to two (2) other residents but did not give any medications to Resident #1. Review of an email dated 2/26/2025 by Licensed Practical Nurse #3 and sent to Director of Nursing #1, documented they got to the unit at 7:00 AM and Licensed Practical Nurse #2 was there and handed them the keys stating they had to leave in a hurry. Licensed Practical Nurse #3 then began counting the narcotics on both sides of the unit and noticed the B side medication cart was missing the blister pack of Oxycontin. Licensed Practical Nurse #3 texted Licensed Practical Nurse #2 and asked them what happened. Licensed Practical Nurse #2 responded back and stated, 'They were going to be honest. They did not count the narcotics at all on their shift.' General Statement dated 2/26/2025 written by Director of Nursing #1, documented a phone interview with Trooper #1 and Licensed Practical Nurse #2. Licensed Practical Nurse #2 stated they did not count at all with Licensed Practical Nurse #1, who they were relieving. Licensed Practical Nurse #2 stated they took Licensed Practical Nurse #1's 'word that everything was good.' (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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	General Statement dated 2/27/2025 written by Licensed Practical Nurse #2, documented the off-going nurse (Licensed Practical Nurse #1) was at the medication cart finishing up their work and asked them if they wanted them to leave the medications in the medication cart, and they told them to leave them there. Licensed Practical Nurse #2 documented, 'at no point did they count the narcotics with [Licensed Practical Nurse #1].' The facility investigation report for missing narcotics dated 3/4/2025, for date of incident 2/24/2025, by Director of Nursing #1. Incident: missing narcotics on unit 2. Oxycontin extended release ten (10) milligrams, twenty (20) tablets missing. Last administration of Oxycontin was by Licensed Practical Nurse #1 at 10:18 PM. It documented: Licensed Practical Nurse #1 stated they counted all narcotics with Licensed Practical Nurse #2 and was instructed by them to place all narcotics back into the medication cart narcotic box. Licensed Practical Nurse #2 stated they were not present for the count but did tell the other nurse to keep the medications in the lock box in the medication cart. Licensed Practical Nurse #2 stated they never removed any medications from the lock box during their shift. Oxycontin extended release ten (10) milligrams was not scheduled to be administered on the 11:00 PM to 7:00 AM shift. The 7:00 AM to 3:00 PM nurse on 2/24/2025 discovered the count was not accurate and 20 pills were missing and notified the Director of Nursing. At time of narcotics reported missing, narcotic cabinets were inspected with no damage noted. All narcotics counted with no discrepancies. Medication carts searched. State police and Bureau of Narcotic Enforcement were notified of missing medications. Employees received disciplinary action regarding failure to perform appropriate narcotic count. Narcotic handling education to be completed for all nurses. Incident was reported to the New York State Department of Health. During an interview on 4/23/2025 at 3:09 PM, Licensed Practical Nurse #1 stated they had already met with the Department of Health in the Director of Nursing #1's office in February 2025 and gave a written statement. They stated they never signed anything about not doing a narcotic count and never had a verbal conversation with the Director of Nursing #1 or the Assistant Director of Nursing. During an interview on 4/23/2025 at 3:19 PM, Licensed Practical Nurse #2 stated they all got in trouble for not doing the narcotic count. They stated, 'that was a big thing for us. We were just taking the keys without counting.' They stated they all knew each other and trusted each other. They stated it was a 'big mistake' and they would never do it again. Order Recap Report for order date 2/1/2025 to 4/25/2025, documented an order dated 2/24/2025 for Oxycontin Oral Tablet extended release 12 Hours Abuse-Deterrent 10 milligram (Oxycodone HCl), give one (1) tablet by mouth two (2) times a day for pain for 14 days. The order start date was 2/24/2025 and end date was 3/10/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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	Documentation on the a) Individual Controlled Medication Record was inconsistent with documentation on the b) Medication Administration Record: Individual Controlled Medication Record for Resident #1 dated 2/25/2025, documented Oxycontin Oral Tablet ten (10) milligrams extended release, give one (1) tablet by mouth two (2) times a day for pain for 14 days. The medication was received 2/25/2025. Medication Administration Record dated February 2025, documented Oxycontin Oral Tablet extended release 12 Hours Abuse-Deterrent 10 milligram (Oxycodone HCl) was scheduled to be given daily at 9:00 AM and 9:00 PM. The order start date was 2/24/2025 at 9:00 PM. 2/25/2025 a) did not document any administrations. The first documented administration was on 2/26/2025 at 9:00 PM. 2/25/2025 b) Oxycontin extended release ten (10) milligrams was administered by Licensed Practical Nurse #6. During an interview on 4/25/2025 at 2:02 PM, Administrator #1 stated they would be starting education related to missed medications, failure to notify the provider, and documentation on the medication administration record. During an observation on 4/23/2025 at 10:56 AM on unit 6 (A-side), the untitled narcotic count signature sheets by the on-coming and off-going nurse dated April 2025 were reviewed. The sheets did not consistently document signatures by the on-coming and off-going nurse. For instance, 4/20/2025 days on, days off, evenings on, and evenings off did not document a signature for the nurse. During an interview with Licensed Practical Nurse #17 on 4/23/2025 at 11:02 AM, they stated they were aware of the ongoing investigation by the Bureau of Narcotic Enforcement. They stated they usually reviewed all the narcotic books and if they found a shift that was not signed, they would find the nurse who worked the shift on 4/20/2025 and would have them sign the book. Immediately following the interview, Licensed Practical Nurse #17 was observed reviewing the narcotic count sheets and was writing on them. Review of the Employee Education Attendance Record for Controlled Substances documented Licensed Practical Nurse #17 attended the training on 3/07/2025. During an observation on 4/23/2025 at 11:10 AM on unit 5 (A-side), the untitled narcotic count signature sheets by the on-coming and off-going nurse dated April 2025 were reviewed. The sheets did not consistently document signatures by the on-coming and off-going nurse. For instance, 4/20/2025 nights on, 4/21/2025 nights off, and 4/22/2025 days on and days off did not document a signature for the nurse. During an interview on 4/23/2025 at 11:16 AM, Licensed Practical Nurse #18 stated they had education on narcotics in late February/early March 2025 and stated narcotics were to be counted before and after each shift and discrepancies reported. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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	During an observation on 4/23/2025 at 11:18 AM on unit 4 (A-side), the untitled narcotic count signature sheets by the on-coming and off-going nurse dated April 2025 were reviewed. The sheets did not consistently document signatures by the on-coming and off-going nurse. For instance, 4/1/2025 nights on, days off, evenings on, evenings off and nights on did not document a signature for the nurse. During the observation Licensed Practical Nurse #4 was observed writing in the unit's (B-side) narcotic count sheet book. During an interview on 4/23/2025 at 11:24 AM, Licensed Practical Nurse #4 stated they did not recall having any formal training about the narcotic counts and/or signing the narcotic count sheets. Review of the Employee Education Attendance Record for Controlled Substances documented Licensed Practical Nurse #4 attended the training on 3/04/2025. During an observation on 4/23/2025 at 11:18 AM on unit 3 (B-side), the untitled narcotic count signature sheets by the on-coming and off-going nurse dated April 2025 were reviewed. The sheets did not consistently document signatures by the on-coming and off-going nurse. For instance, 4/13/2025 nights on, days on, days off, and nights on did not document a signature for the nurse. During an interview on 4/23/2025 at 11:40 AM, Registered Nurse #2 stated they received education in March about the narcotic counts and signing the sheets. They stated they looked at the narcotic count books frequently and stated that sometimes 'staff do miss' and had to be told to sign it. They stated they would check to see who worked the shift on 4/20/2025 and would have them sign it. Review of the Employee Education Attendance Record for Controlled Substances documented Registered Nurse #2 attending the training on 3/4/2025. During an observation on 4/23/2025 at 11:55 AM on unit 2 (B-side), the untitled narcotic count signature sheets by the on-coming and off-going nurse dated April 2025 were reviewed. The sheets did not consistently document signatures by the on-coming and off-going nurse. For instance, 4/23/2025 nights off and days on did not document a signature for the nurse. During an interview on 4/23/2025 at 12:02 PM, Licensed Practical Nurse #1 stated they arrived on the unit after 9:00 AM. They stated the nurse working the unit prior to 9:00 AM, (Licensed Practical Nurse #6) should have counted the narcotics and signed the sheet. Surveyor asked if a count was done upon their arrival to the unit and they stated they counted for the B-side with Licensed Practical Nurse #6 and should have signed for 'days on.' They stated there should have been two (2) signatures on the line for 'days on,' theirs and Licensed Practical Nurse #6's. Review of the Employee Education Attendance Record for Controlled Substances documented Licensed Practical Nurse #1 attended the training on 2/27/2025. During an observation on 4/23/2025 at 2:18 PM on unit 1, the untitled narcotic count signature sheets by the on-coming and off-going nurse dated April 2025 were reviewed. The sheets did not consistently document signatures by the on-coming and off-going nurse. For instance, 4/20/2025 did not document any nurse signatures for the entire day on all three (3) shifts. During an interview on 4/23/2025 at 2:27 PM, Licensed Practical Nurse #19, stated they received education a while ago on counting narcotics and signing the narcotic sheet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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	During an interview on 4/24/2025 at 3:10 PM, Director of Nursing #1 stated there was house-wide education in February 2025, regarding counting narcotics with another nurse (on-coming and off-going) signing narcotic books and making sure control records were signed and dated. During an interview on 4/24/2025 at 2:02 PM, Administrator #1 stated they started education today, 4/24/2025, regarding narcotic count sign on/off with two (2) nurses. They stated the Educator would be auditing the narcotic sheets every sheet for the next two (2) weeks and then daily on the dayshift. They stated the Educator would audit the dayshift, 7:00 AM to 3:00 PM and the nursing supervisor would audit 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM. They stated that after that they would decide if the audits would be continued weekly or daily. 10 New York Code Rules and Regulations 415.18(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews during an abbreviated survey (Case #s NY00376223 and NY00377464), the facility did not ensure residents were free from significant medication errors for seven (7) (Resident #s 2, 3, 4, 5, 6, 7, and 12) of seven (7) residents reviewed. Specifically, the facility did not ensure accurate medication administration and documentation of controlled substances for a) Clonazepam (treats anxiety) for Resident #s 2, 5, and 12, b) Clonazepam and Tramadol (narcotic pain medication) for Resident #3, c) Alprazolam (treats anxiety) for Resident #4, and d) Oxycodone (narcotic pain medication) for Resident #s 6 and 7. This is evidenced by: The Policy and Procedure titled, Controlled Substance/Narcotic Management Protocol, reviewed 1/2025, documented it was the facility's policy to prescribe, administer, store and destroy all controlled substances within accepted regulations of the responsible governing body. All controlled substances ordered would be ordered in accordance with best practice and regulations. With each administration, the nurse must document the date, time, prior count and post administration count of the remainder of the medication and sign in the controlled substance logbook in addition to the medication administration record. In the event a resident did not take a controlled substance that had already been removed from its package, the nurse must document the details of the failed administration and destroy the medication in the presence of another nurse. Destruction must render the substance irretrievable. Two (2) nurses must witness and sign for all narcotic wastage in the controlled substance binder on the unit and document the new count. The nursing supervisor or Unit Manager must be made aware of the destruction and circumstances regarding same immediately. Resident #5: Resident #5 was readmitted to the facility with diagnoses of unspecified depression (mental health disorder that affects how a person feels, thinks, and handles daily activities), anxiety disorder (mental health disorder that causes fear, dread and other symptoms that are out of proportion to the situation), and conduct disorder (a mental health condition that involves a persistent pattern of aggressive and antisocial behaviors). The Minimum Data Set (an assessment tool) dated [DATE], documented the resident had moderate cognitive impairment. The resident was able to make themselves understood and understood others. Care Plan for Resident #5 used Psychotropic Medications (drugs that affect a person's mental state) related to anxiety and depression, revised [DATE]. Interventions documented give medications ordered by the physician; monitor/document side effects and effectiveness. Medication Review Report for date range [DATE] to [DATE], documented an order dated [DATE] for Clonazepam oral tablet 0.5 milligram, give one (1) tablet by mouth in the morning for five (5) administrations. The order start date was [DATE]. Review of the a) Individual Controlled Medication Record and the b) electronic Medication Administration Record dated February 2025 documented: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Individual Controlled Medication Record for Resident #5 dated [DATE], documented Clonazepam 0.5 milligram, give one (1) tablet by mouth in the morning for 5 administrations. Medication Administration Record dated February 2025, documented Clonazepam 0.5 milligram, give one (1) tablet by mouth in the morning for five (5) administrations. The medication was scheduled to be given at 10:00 AM. Documentation on the a) Individual Controlled Medication Record was inconsistent with documentation on the b) Medication Administration Record. For instance: a) Clonazepam 0.5 milligram was administered on [DATE] at 10:47 AM, [DATE] at 8:00 AM, [DATE] at an illegible time, [DATE] at 8:00 AM, and [DATE] at 9:00 AM, respectively, for a total of five (5) administrations. b) Clonazepam 0.5 milligram was administered at 10:00 AM on [DATE], [DATE], [DATE], and [DATE], for a total of four (4) administrations. Order Summary Report for order date range [DATE] to [DATE], documented an order dated [DATE] for Clonazepam oral tablet 1 milligram, give one (1) tablet by mouth at bedtime for anxiety for fourteen (14) days. The order was started on [DATE] and was to end on [DATE]. Review of the a) Individual Controlled Medication Record and the b) electronic Medication Administration Record dated [DATE] documented: Individual Controlled Medication Record for Resident #5 dated [DATE], documented Clonazepam 1 milligram, give one (1) tablet by mouth at bedtime for anxiety for fourteen (14) days. Medication Administration Record dated [DATE], documented Clonazepam 1 milligram, give one (1) tablet by mouth at bedtime for anxiety for fourteen (14) days. The medication was scheduled to be given at 9:00 PM. Documentation on the a) Individual Controlled Medication Record was inconsistent with documentation on the b) Medication Administration Record. For instance: [DATE] a) Clonazepam 1 milligram was administered at 9:00 AM by Licensed Practical Nurse #8, when it was scheduled for 9:00 PM. [DATE] b) Medication Administration Record did not document the administration. [DATE] a) Clonazepam 1 milligram was administered at 9:00 AM by Licensed Practical Nurse #8, when it was scheduled for 9:00 PM. [DATE] b) Medication Administration Record did not document the administration. [DATE] a) Clonazepam 1 milligram was administered at 9:00 AM by Licensed Practical Nurse #8, when it was scheduled for 9:00 PM. [DATE] b) Medication Administration Record did not document the administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication Administration Incident Report for Resident #5, date of discovery [DATE] at 9:00 PM. Date of error: [DATE], [DATE], and [DATE] at 9:00 AM. Type of error: wrong medication administered. Description of medication error: [DATE], [DATE], and [DATE] clonazepam one (1) milligram was administered at 9:00 AM. The order was to administer at bedtime. The report was signed by Licensed Practical Nurse #8 on [DATE]. Notice of Disciplinary Action for Licensed Practical Nurse #8 dated [DATE], documented a first and final warning for a medication error. Licensed Practical Nurse #8 gave Klonopin (clonazepam) on [DATE], [DATE], and [DATE], without a physician order. Medication was signed out on the narcotic sheet. Loss of Controlled Substances Report dated [DATE] by Director of Nursing #1, documented Resident #5 had a standing order for Clonazepam one (1) milligram to be administered at bedtime. Licensed Practical Nurse #8 administered the medication at 9:00 AM on [DATE], [DATE], and [DATE], without a physician's order. Medication was signed out on the narcotic sheet by the nurse. Resident #3: Resident #3 was admitted to the facility with diagnoses of unspecified schizophrenia (a condition and a spectrum of disorders involving a disconnection from reality), anxiety disorder, and conduct disorder. The Minimum Data Set, dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and understood others. Care Plan for Resident Exhibits Behavior Symptoms such as anxious, agitated and refusal of care and medications; socially inappropriate/verbally aggressive/abusive; physically aggressive/abusive; hallucinations (seeing, hearing, feeling or smelling something that does not exist); delusions (an unshakable belief in something that is untrue), revised [DATE]. Interventions documented administer psychotropic medications as ordered. Order Summary Report for order date range [DATE] to [DATE], documented an order dated [DATE] for Clonazepam 0.5 milligram, give one (1) tablet by mouth two (2) times a day for anxiety for fourteen (14) days. The order was started on [DATE] and was to end on [DATE]. Review of the a) Individual Controlled Medication Record and the b) electronic Medication Administration Record dated February 2025 documented: Individual Controlled Medication Record for Resident #3 dated [DATE], documented Clonazepam 0.5 milligram, give one (1) tablet by mouth two times a day for anxiety for fourteen (14) days. Medication Administration Record dated February 2025, documented Clonazepam 0.5 milligram, give one (1) tablet by mouth two times a day for anxiety for fourteen (14) days. The medication was scheduled to be given at 9:00 AM and 9:00 PM. The order was to start on [DATE] at 9:00 PM and ended on [DATE] at 9:00 AM. Documentation on the a) Individual Controlled Medication Record was inconsistent with documentation on the a) Medication Administration Record. For instance: [DATE] a) Clonazepam 0.5 milligram was administered at 2:00 PM, when it was scheduled to be given at 9:00 AM and 9:00 PM, and was already given at 9:00 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] b) Medication Administration Record did not document the 2:00 PM administration. [DATE] a) Clonazepam 0.5 milligram was administered at 9:00 PM, when the order had expired after the 9:00 AM administration on [DATE], and there was no new order until [DATE] at 9:00 PM. [DATE] b) Medication Administration Record did not document the administration. [DATE] a) Clonazepam 0.5 milligram was administered at 9:00 AM, when there was no new order until [DATE] at 9:00 PM. [DATE] b) Medication Administration Record documented the order was to start on [DATE] at 9:00 PM and did not document the 9:00 AM administration. Order Summary Report for order date range [DATE] to [DATE], documented an order dated [DATE] for Clonazepam 0.5 milligram, give one (1) tablet by mouth two (2) times a day for anxiety for fourteen (14) days. The order was started on [DATE] and was to end on [DATE]. Review of the a) Individual Controlled Medication Record and the b) electronic Medication Administration Record dated March documented: Individual Controlled Medication Record for Resident #3 dated [DATE], documented Clonazepam 0.5 milligram, give one (1) tablet by mouth two (2) times a day for anxiety for fourteen (14) days. Medication Administration Record dated [DATE], documented Clonazepam 0.5 milligram, give one (1) tablet by mouth two (2) times a day for anxiety for fourteen (14) days. The medication was scheduled to be given at 9:00 AM and 9:00 PM. Documentation on the a) Individual Controlled Medication Record was inconsistent with documentation on the b) Medication Administration Record. For instance: [DATE] a) Clonazepam 0.5 milligram was administered at 9:00 AM and was documented as wasted. There was no documentation that another nurse witnessed the waste. A subsequent entry documented the medication was administered at 10:00 AM. [DATE] b) Medication Administration Record documented one (1) administration at 9:00 AM. Order Summary Report for order date range [DATE] to [DATE], documented an order dated [DATE] for Tramadol HCl oral tablet 50 milligrams, give one (1) tablet by mouth two (2) times a day for fourteen (14) days. The order was started on [DATE] and was to end on [DATE]. Review of the a) Individual Controlled Medication Record and the b) electronic Medication Administration Record dated February documented: Individual Controlled Medication Record for Resident #3 dated [DATE], documented Tramadol HCl oral tablet 50 milligrams, give one (1) tablet by mouth two (2) times a day for fourteen (14) days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication Administration Record dated February 2025, documented Tramadol HCl oral tablet 50 milligrams, give one (1) tablet by mouth two (2) times a day for fourteen (14) days. The medication was scheduled to be given at 9:00 AM and 9:00 PM. Documentation on the a) Individual Controlled Medication Record was inconsistent with documentation on the b) Medication Administration Record. For instance: [DATE] a) Tramadol 50 milligram was administered on [DATE] at 9:00 PM by Licensed Practical Nurse #3 and at 9:00 AM by Licensed Practical Nurse #7, respectively. [DATE] b) Medication Administration Record documented the medication was administered on [DATE] at 9:00 AM by Licensed Practical Nurse #5 and at 9:00 PM by Licensed Practical Nurse #3. [DATE] a) There were no documented administrations. [DATE] b) Medication Administration Record documented the medication was administered on [DATE] at 9:00 AM by Licensed Practical Nurse #7 and at 9:00 PM by Licensed Practical Nurse #9. Order Summary Report for order date range [DATE] to [DATE], documented an order dated [DATE] for Tramadol HCl oral tablet 50 milligrams, give one (1) tablet by mouth two (2) times a day for fourteen (14) days. The order was started on [DATE] and was to end on [DATE]. Review of the a) Individual Controlled Medication Record and the b) electronic Medication Administration Record dated [DATE] documented: Individual Controlled Medication Record for Resident #3, documented Tramadol HCl oral tablet 50 milligrams, give one (1) tablet by mouth two (2) times a day for fourteen (14) days. Medication Administration Record dated [DATE], documented Tramadol HCl oral tablet 50 milligrams, give one (1) tablet by mouth two (2) times a day for fourteen (14) days. The medication was scheduled to be given at 9:00 AM and 9:00 PM. Documentation on the a) Individual Controlled Medication Record was inconsistent with documentation on the b) Medication Administration Record. For instance: [DATE] a) Tramadol 50 milligram was administered at 9:00 AM, when the order ended on [DATE] at 9:00 PM and there was no new physician order until [DATE] at 9:00 AM. [DATE] b) Medication Administration Record did not document the administration. [DATE] a) Tramadol 50 milligram was administered at 9:00 AM, when there was no new physician order until [DATE] at 9:00 AM. [DATE] b) Medication Administration Record did not document the administration. Order Summary Report for order date range [DATE] to [DATE], documented an order dated [DATE] for Tramadol HCl oral tablet 50 milligrams, give one (1) tablet by mouth two (2) times a day for fourteen (14) days. The order was started on [DATE] and was to end 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
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the a) Individual Controlled Medication Record and the b) electronic Medication Administration Record dated [DATE] documented: Individual Controlled Medication Record for Resident #3 dated [DATE], documented Tramadol HCl oral tablet 50 milligrams, give one (1) tablet by mouth two (2) times a day for fourteen (14) days. Medication Administration Record dated March and [DATE], documented Tramadol HCl oral tablet 50 milligrams, give one (1) tablet by mouth two (2) times a day for fourteen (14) days. The medication was scheduled to be given at 9:00 AM and 9:00 PM. Documentation on the a) Individual Controlled Medication Record was inconsistent with documentation on the b) Medication Administration Record. For instance: [DATE] a) Tramadol 50 milligram was administered at 9:00 PM, when the order ended on [DATE] at 9:00 PM and there was no new physician order until [DATE] at 8:59 AM. [DATE] b) Medication Administration Record did not document the administration. [DATE] a) Tramadol 50 milligram was administered at 9:00 AM, when there was no new physician order until [DATE] at 8:59 AM. [DATE] b) Medication Administration Record did not document the administration. [DATE] a) Tramadol 50 milligram was administered at 9:00 AM and 9:00 PM, when there was no new physician order until [DATE] at 8:59 AM. [DATE] b) Medication Administration Record did not document the administrations. Resident #6: Resident #6 was readmitted to the facility with diagnoses of spinal stenosis lumbar region (narrowing of the spinal canal in the lower back) without neurogenic claudication (condition that causes pain, weakness, and heaviness in the legs when walking), sciatica unspecified side (pain that travels along the path of the sciatic nerve from the buttocks and down each leg) and other chronic pain. The Minimum Data Set, dated [DATE], documented the resident was cognitively intact. The resident was able to make themselves understood and understood others. Care Plan for Resident has Musculoskeletal Impairment related to spinal stenosis, vertebrae fracture (broken bone in spine), and osteoporosis (disease that weakens the bones), revised [DATE]. Intervention documented administer pain medications per physician orders. Order Summary Report for order date range [DATE] to [DATE], documented an order dated [DATE] for Oxycodone HCl oral tablet ten (10) milligrams, give one (1) tablet by mouth every six (6) hours as needed for pain for fourteen (14) days. Review of the a) Individual Controlled Medication Record and the b) electronic Medication Administration Record dated March and [DATE] documented: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Individual Controlled Medication Record for Resident #6 dated [DATE], documented Oxycodone HCl oral tablet 10 milligrams, give one (1) tablet by mouth every six (6) hours as needed for pain for fourteen (14) days. Medication Administration Record dated [DATE], documented Oxycodone HCl oral tablet ten (10) milligrams, give one (1) tablet by mouth every six (6) hours as needed for pain for fourteen (14) days. Documentation on the Individual Controlled Medication Record was inconsistent with documentation on the Medication Administration Record. For instance: [DATE] a) Oxycodone ten (10) milligram was administered at 9:00 PM. [DATE] b) Medication Administration Record did not document the administration. [DATE] a) Oxycodone ten (10) milligram was administered at 8:00 AM and 2:00 PM. [DATE] b) Medication Administration Record did not document the administrations. [DATE] a) Oxycodone ten (10) milligram was administered at 10:00 PM, 8:00 AM, and 1:00 PM respectively. [DATE] b) Medication Administration Record documented one (1) administration on [DATE] at 2:18 PM. [DATE] a) Oxycodone ten (10) milligram was administered at 1:35 PM by Licensed Practical Nurse #10. [DATE] b) Medication Administration Record did not document the 1:35 PM administration. Also, there was documentation of an administration at 9:48 PM by Licensed Practical Nurse #10, that was not documented on the Individual Controlled Medication Record. [DATE] a) Oxycodone ten (10) milligram was administered at 7:00 PM. [DATE] b) Medication Administration Record did not document the administration. [DATE] a) did not document any administrations. [DATE] b) Medication Administration Record documented one (1) administration at 11:45 PM. [DATE] a) Oxycodone ten (10) milligram was administered at 5:00 PM, 11:30 PM, 7:00 AM, 3:00 PM, and 9:12 PM, respectively. [DATE] b) Medication Administration Record only documented one (1) administration on [DATE] at 9:12 PM administration. [DATE] a) Oxycodone ten (10) milligram was administered at 1:00 PM. [DATE] b) Medication Administration Record did not document the administration. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. Building B. Wing	06/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Grand Rehabilitation and Nursing at Barnwell	3230 Church Street Valatie, NY 12184

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Loss of Controlled Substances Report dated [DATE] by Director of Nursing #1, Lost/stolen controlled substance listing documented one (1) Oxycodone ten (10) milligram tablet. Date/time of incident was [DATE] at 1:30 PM. Name of suspect documented Licensed Practical Nurse #10. It documented Resident #6 requested prn (as needed) pain medication and was informed they already received it at 1:35 PM. Resident #6 stated they never requested pain medication at that time because they were in therapy. During an interview on [DATE] at 10:29 AM, Licensed Practical Nurse #4 stated they were aware of Resident #5's Clonazepam administration issues. They stated they noticed a problem with the medication administration on the evening shift of [DATE], when they went to give the 9:00 PM dose of clonazepam. They looked at the prior administration on the narcotic control sheet and saw it was given at 9:00 AM on [DATE] and [DATE] and reported the errors on [DATE] to the Director of Nursing #1. They stated the errors were made by Licensed Practical Nurse #8. They stated the narcotic count was correct, but they noticed that Licensed Practical Nurse #8 gave the medication at 9:00 AM. They told the Director of Nursing #1 they could not give the daily dose because it was already given, and Licensed Practical Nurse #4 was told they had to call the doctor. The Assistant Director of Nursing stated they would call the physician and then called the Nurse Practitioner. When they called, they said they had a resident who received their medication early and the Nurse Practitioner told them to hold the medication. Licensed Practical Nurse #4 asked Resident #5 if they got their Clonazepam in the morning and resident said they take that at night. They stated the resident knew the color of the pill and that they get the pill at bedtime. During an interview on [DATE] at 3:06 PM, Registered Nurse #1 stated they knew the 'rules' regarding narcotic medication administration. They stated when a narcotic was administered the narcotic control record, and the electronic medication administration record were to be signed/documented. They stated signing the narcotic control record but not signing the electronic medication record meant the nurse did not give the medication to the resident. They stated a nurse needed another nurse to witness the wasting of a narcotic medication and the witness needed to sign the narcotic control record that they witnessed the waste. During an interview on [DATE] at 3:10 PM, Director of Nursing #1 stated there was house-wide education in February 2025, regarding counting narcotics with another nurse (on-coming and off-going) signing narcotic books and making sure control records were signed and dated. When narcotics are administered, they need to be signed out on the control record and then documented in the electronic medication record once they are administered. They stated narcotics needed to be wasted with a second nurse and documented why it was wasted, with the second nurse signature on the narcotic control record. During an interview on [DATE] at 2:02 PM, Administrator #1 stated they started education today, [DATE], regarding narcotic count sign on/off with two (2) nurse, documentation and reason for wasting narcotics on the control record. They stated the Educator would be auditing the narcotic sheets every sheet for the next two (2) weeks and then daily on the dayshift. They stated the Educator would audit the dayshift, 7:00 AM to 3:00 PM and the nursing supervisor would audit 3:00 PM to 11:00 PM and 11:00 PM to 7:00 AM. They stated that after that they would decide if the audits would be continued weekly or daily. 10 New York Code of Rules and Regulations 415.12(m)(2)