STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366067	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Care Center of Milan	185 S Main St Milan, OH 44846

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 - Some	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366067	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Care Center of Milan	185 S Main St Milan, OH 44846

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 - Some	Based on review of facility self-reported incidents, review of a medication incident investigation, review of staff statements, interviews with staff, and review of facility policy, the facility failed to report allegations of abuse and neglect. This had the potential to affect 38 residents (#2, #5, #8, #10, #11, #13, #14, #16, #18, #19, #22, #26, #30, #37, #38, #40, #44, #46, #49, #52, #53, #55, #56, #88, #57, #59, #61, #63, #66, #67, #70, #72, #77, #78, #79, #80, #82, and #85) residing on unit one. The facility census was 87. Review of a statement dated 05/21/25 by Licensed Practical Nurse (LPN) #160 revealed she had worked a 12-hour day shift then gave report to the 12-hour night shift nurse LPN #174. LPN #160 revealed she had not left until around 8:00 P.M. LPN #160 stated as she was gathering her things, LPN #174 started putting cups out and putting Tylenol PM and melatonin in everyone's medication cups, then started putting resident medications in those same cups. LPN #160 noted during training LPN #174 would watch movies and sleep on her shift. LPN #160 revealed she called and reported it to the Assistant Director of Nursing (ADON) #196 this same night, wrote a statement and placed it under ADON #196's door. Further review of the investigation revealed there was no documentation the allegations reported on 05/21/25 were investigated.Review of a statement dated 06/04/25 written by Registered Nurse (RN) #212 revealed on 06/04/25 around 7:20 P.M. she stopped in the 100 halls where LPN #174 was standing. RN #212 noticed at least four pill cups with Tylenol PM in them (blue pills with P525 on them). RN #212 stated to LPN #174, Wow you have that many people on Tylenol PM? and LPN #174 replied Yeah, I have a few and turned to give someone their medications. When LPN #174 returned to the cart, RN #212 stated she proceeded to take a picture of the pill cups on her cart. RN #212 stated she had seen LPN #174 prep her medications when she worked but had never got close enough to see what they were until tonight. RN #212 stated she immediately left and notified the Assistant Director of Nursing (ADON) #196 and sent her the pictures.Review of a statement dated 06/05/25 by LPN #174 and emailed to the Former Interim Director of Nursing (FIDON) #800 revealed she was off five days in a row and when she returned she had no clue what the new orders were. LPN #174 stated she always put Tylenol, Melatonin and Tylenol PM's in cups just in case there is a new order. LPN #174 also stated she pre-poured water cups before passing meds, so she was ready, it is available and easier. LPN #174 stated she was doing her medication pass last night at the nurses' station and RN #212 asked Is that Tylenol PM? Do you have that many orders for them? LPN #174 acknowledged what they were and kept on doing the medication pass. LPN #174 stated do I have time before med pass to check all the residents new orders to see if there are new orders for it, so I could not answer her second question. LPN #174 stated RN #212 walked away then came back with her phone out and took a picture of the medication cart and walked away. LPN #174 stated with that being said, lastly, no Tylenol PM were given and the pills went back into the bottle at the end of my medication pass. Review of a statement dated 06/06/25 by ADON #196 revealed on 05/21/25 she had received a call from LPN #160 who had worked on unit one that day. LPN #160 reported LPN #174 started pre-pouring the residents' nighttime medications and putting Tylenol PM in all the cups. ADON #196 noted no residents on unit one had an order for Tylenol PM. ADON #196 stated she called the Former Director of Nursing (FDON) #566 to report what LPN #160 had reported. ADON #196 revealed FDON #566 told her she had not believed LPN #160 and said, even if it were true, without proof there was nothing we could do. ADON #196 stated when she came in the next day, she took the bottle of Tylenol PM out of the cart since no one had an order for it. ADON #196 noted by the next week there was a new bottle in the cart and opened, the DON at the time was notified. Review of a statement dated 06/09/25 by FIDON #800 noted speaking with Physician #190 on 06/06/26 regarding concerns the facility was investigating a nurse for giving Tylenol PM to residents without an order. Physician #190 had no medical recommendations for necessary attention to this situation.Review of the facility self-reported incidents (SRI) revealed the incidents alleged on 05/21/25 and 06/04/25 had not been reported to the state agency. Interview on 09/03/25 at 8:52 A.M., the Administrator revealed the facility had a report of a nurse giving medications on 06/04/25 without a physician order but could not prove it and the nurse denied giving the medications without an order. The Administrator revealed the nurse was terminated for pre-pouring her medications.Interview on 09/04/25 at 8:50 A.M., ADON #196 revealed RN #212 thought LPN #174 was giving residents Tylenol PM without an order. ADON #196 revealed she reported the incident on 06/04/25 to FIDON #800 who took over the investigation. ADON #196 denied prior knowledge of allegations of LPN #174 administering medications without an order. ADON #196 was given LPN #160's statement dated 05/21/25 to review. ADON #196

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366067	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Care Center of Milan	185 S Main St Milan, OH 44846

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366067	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Care Center of Milan	185 S Main St Milan, OH 44846

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a medication incident investigation, review of staff statements, interviews with staff and residents, and review of facility policy, the facility failed to investigate allegations of abuse and neglect alleged on 05/21/25 and failed to thoroughly investigate an allegation of abuse alleged on 06/04/25. This had the potential to affect 38 residents (#2, #5, #8, #10, #11, #13, #14, #16, #18, #19, #22, #26, #30, #37, #38, #40, #44, #46, #49, #52, #53, #55, #56, #88, #57, #59, #61, #63, #66, #67, #70, #72, #77, #78, #79, #80, #82, and #85) residing on unit one. The facility census was 87. Review of the medical record for Resident #56 revealed an admission date of 07/09/20. Diagnoses included type two diabetes mellitus, bipolar disorder, paranoid schizophrenia, anxiety, hypertension, and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition.Review of Resident #56's physician orders from 05/21/25 through 06/04/25 revealed the resident had no orders for Tylenol PM (pain reliever/sleep aid). Review of a physician order dated 06/13/25 revealed the resident was ordered Tylenol PM extra strength 500 milligram (mg)/25 mg, one tablet by mouth as needed for insomnia at bedtime.Review of the medical record for Resident #55 revealed an admission date of 02/21/21. Diagnoses included schizoaffective disorder bipolar type, paranoid personality disorder, and depressive disorder. Review of the MDS quarterly assessment dated [DATE] revealed the resident had intact cognition.Review of Resident #55's physician orders from 05/21/25 through 06/04/25 revealed the resident had no orders for Tylenol PM. Review of a physician order dated 06/25/25 revealed an order for Tylenol PM extra strength 500 mg/25 mg, one tablet by mouth every 24 hours as needed for insomnia. Review of a statement dated 05/21/25 by Licensed Practical Nurse (LPN) #160 revealed working a 12-hour day shift then gave report to the 12-hour night shift nurse LPN #174. LPN #160 revealed she had not left until around 8:00 P.M. LPN #160 stated as she was gathering her things, LPN #174 started putting cups out and putting Tylenol PM and melatonin in everyone's medication cups, then started putting resident medications in those same cups. LPN #160 noted during training LPN #174 would watch movies and sleep on her shift. LPN #160 revealed she called and reported it to the Assistant Director of Nursing (ADON) #196 this same night, wrote a statement and placed it under ADON #196's door. Further review of the investigation revealed there was no documentation the allegations reported on 05/21/25 were investigated. Review of the staffing assignment forms from 05/21/25 through 06/04/25 revealed LPN #174 worked on unit one on 05/21/25, 05/22/25, 05/26/25, 05/27/25, 05/28/25, 06/03/25, and 06/04/25.Review of a statement dated 06/04/25 written by Registered Nurse (RN) #212 revealed on 06/04/25 around 7:20 P.M. she stopped in the 100 halls where LPN #174 was standing. RN #212 noticed at least four pill cups with Tylenol PM in them (blue pills with P525 on them). RN #212 stated to LPN #174, Wow you have that many people on Tylenol PM? and LPN #174 replied Yeah, I have a few and turned to give someone their medications. When LPN #174 returned to the cart, RN #212 stated she proceeded to take a picture of the pill cups on her cart. RN #212 stated she had seen LPN #174 prep her medications when she worked but had never got close enough to see what they were until tonight. RN #212 stated she immediately left and notified the Assistant Director of Nursing (ADON) #196 and sent her the pictures. Review of Resident #56's statement dated 06/05/25 taken by Former Interim Director of Nursing (FIDON) #800 revealed the resident was asked if she had been receiving Tylenol PM last night or anytime. Resident #56 stated she had not wished to answer and had not wanted to get anyone in trouble. Resident #56 stated she would like the nurse practitioner to be asked for an order for Tylenol PM because she needed it to help her sleep. FIDON #800 noted the resident had an order for Tylenol 325 milligrams and order for melatonin 10 mg at bedtime. Review of a statement dated 06/05/25 by LPN #174 and emailed to FIDON #800 revealed she was off five days in a row and when she returned she had no clue what the new orders were. LPN #174 stated she always put Tylenol, Melatonin and Tylenol PM's in cups just in case there is a new order. LPN #174 also stated she pre-poured water cups before passing meds, so she was ready, it is available and easier. LPN #174 stated she was doing her medication pass last night at the nurses' station and RN #212 asked Is that Tylenol PM? Do you have that many orders for them? LPN #174 acknowledged what they were and kept on doing the medication pass. LPN #174 stated do I have time before med pass to check all the residents new orders to see if there are new orders for it, so I could not answer her second question. LPN #174 stated RN #212 walked away then came back with her phone out and took a picture of the medication cart and walked away. LPN #174 stated with that being said, lastly no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366067	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Care Center of Milan	185 S Main St Milan, OH 44846

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366067	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Care Center of Milan	185 S Main St Milan, OH 44846

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record, review of a fall investigation, review of staffing assignment records, interviews with staff and residents, and policy review, the facility failed to ensure a resident was reevaluated for transfer assistance after a change in condition and ensure a safe resident transfer. Additionally, the facility failed to ensure falls were immediately reported, immediate post-fall assessments were completed and ensure the completion of a thorough fall investigation. This affected one (#7) of three residents reviewed for falls and had the potential to affect 56 residents residing on unit one and unit two. The facility census was 87. Review of the medical record for Resident #7 revealed an admission date of 02/21/23. Diagnoses included hemiplegia and hemiparesis following cerebral infarction, acquired absence of right leg below the knee, type two diabetes mellitus, and a diabetic foot ulcer. Review of the annual Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition. The resident was at risk for falls.Review of a physician order dated 12/08/23 revealed the resident required the assistance of one staff and pivot transfer with walker. The order was discontinued on 07/01/25. Review of a physical therapy Discharge summary dated [DATE] revealed the resident required supervision or touching assistance with transfers. The resident was discharged from therapy using a walker.Review of a fall risk assessment dated [DATE] revealed the resident was at risk for falls. Review of the plan of care initiated on 02/23/23 revealed the resident had impaired mobility and relied on staff for assistance with activities of daily living (ADL ' s). The resident had a right leg prosthesis. Interventions included extensive assistance by staff with transferring, use of walker for transfers with pivot and the care plan was noted as resolved on 01/22/25. On 01/22/25 the resident was noted as requiring weight bearing assistance with sit to stand, lying to sitting, and transfers. On 02/19/25 an intervention was added for mechanical lift transfers until new prosthetic was received. Review of a nurse ' s note dated 01/27/25 at 1:26 P.M. revealed Resident #7 had a three centimeter (cm) in length by 2.5 cm in width blister noted to the right anterior stump. The resident stated his prosthetic rubs and caused the blister, red patches were also noted. The nurse practitioner was notified with new wound care orders received. The blister was noted as healed on 02/10/25.Review of a nurse ' s note dated 01/28/25 at 8:54 A.M. revealed the resident was scheduled to have his prosthetic leg evaluated by a provider on 02/13/25. There was no documentation in the medical record of the resident attending the appointment. Review of a nurse ' s note dated 01/30/25 at 9:39 A.M. revealed Resident #7 was not wearing prosthetic to right stump related to pain/ill fitting. Appointment scheduled for adjustment. Review of a physician order dated 01/30/25 revealed to not wear prosthetic to right stump until after follow up with orthopedics. Further review of the medical record revealed no documentation the resident ' s transfer status was reevaluated after the inability to wear the right lower extremity prosthesis. Review of the weight documentation revealed the resident weighed 236 pounds on 01/20/25 and 238 pounds on 02/19/25. Review of an incident report dated 02/19/25 at 1:25 P.M. revealed a nursing assistant informed the nurse Resident #7 had a fall two days ago. The resident revealed he had fallen and landed on his buttocks. The nursing assistants helped him up with the help of his roommate to hold the chair then put him back in bed and left the room. Review of statement dated 02/19/25 by Certified Nursing Assistant (CNA) #601 revealed on 02/17/25 CNA #602 went to transfer Resident #7, and he fell. CNA #601 revealed she was only in the room to watch. CNA #601 revealed CNA #602 fell on top of Resident #7. CNA #602 told CNA #601 not to report the fall because Resident #7 was fine and was not hurt. Review of statement dated 02/19/25 by CNA #602 revealed on 02/17/25 Resident #7 said he needed to have a bowel movement. CNA #602 stated normally we transfer to the toilet in shower room but a resident was using the toilet, so we laid Resident #7 down and after he was done, CNA #601 and myself transferred him. Resident #7 was on part of the chair and slid. We asked the resident ' s roommate Resident #67 to push the chair under him while we lifted him into the chair. CNA #602 stated Resident #7 never touched the floor that he was aware of. CNA #602 revealed we were told Resident #7 was either a two assist or a mechanical lift. Review of a statement dated 02/19/25 by CNA #99 revealed CNA #601 notified her at home that Resident #7 fell when CNA #602 attempted to get the resident out of bed with a stand/pivot transfer. CNA #602 and CNA #601 had not used the mechanical lift. CNA #601 stated CNA #602 landed on top of the resident. CNA #601 stated CNA #602 told her not to say a word about the incident. CNA #601 stated she reported the incident to LPN #174. CNA #99 revealed she returned to work today 02/19/25 and Resident #7 ' s roommate was asking questions. CNA #99 revealed she reported the incident to the nurse who notified Former Director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366067	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Care Center of Milan	185 S Main St Milan, OH 44846

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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366067	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Care Center of Milan	185 S Main St Milan, OH 44846

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review, review of a facility medication incident investigation, review of staff statements, staff and resident interviews, and policy review, the facility failed to ensure medications were administered per physician orders. Additionally, the facility failed to assess and monitor for potential medication interactions and adverse medication effects. This affected two (#55, #56) of three residents reviewed for medications and had the potential to affect 38 residents (#2, #5, #8, #10, #11, #13, #14, #16, #18, #19, #22, #26, #30, #37, #38, #40, #44, #46, #49, #52, #53, #55, #56, #88, #57, #59, #61, #63, #66, #67, #70, #72, #77, #78, #79, #80, #82, and #85) residing on unit one. The facility census was 87. Review of the medical record for Resident #56 revealed an admission date of 07/09/20. Diagnoses included type two diabetes mellitus, bipolar disorder, paranoid schizophrenia, anxiety, hypertension, and chronic obstructive pulmonary disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had intact cognition.Review of Resident #56's physician orders from 05/21/25 through 06/04/25 revealed the resident had no orders for Tylenol PM (pain reliever/sleep aid). Review of a physician order dated 06/13/25 revealed the resident was ordered Tylenol PM extra strength 500 mg/25 mg, one tablet by mouth as needed for insomnia at bedtime.Review of the medical record for Resident #55 revealed an admission date of 02/21/21. Diagnoses included schizoaffective disorder bipolar type, paranoid personality disorder, and depressive disorder. Review of the MDS quarterly assessment dated [DATE] revealed the resident had intact cognition. Review of Resident #55's physician orders from 05/21/25 through 06/04/25 revealed the resident had no orders for Tylenol PM. Review of a physician order dated 06/25/25 revealed an order for Tylenol PM extra strength 500 mg/25 mg, one tablet by mouth every 24 hours as needed for insomnia. Review of a statement dated 05/21/25 by Licensed Practical Nurse (LPN) #160 revealed working a 12-hour day shift then gave report to the 12-hour night shift nurse LPN #174. LPN #160 revealed she had not left until around 8:00 P.M. LPN #160 stated as she was gathering her things, LPN #174 started putting cups out and putting Tylenol PM and Melatonin in everyone's medication cups, then started putting resident medications in those same cups. LPN #160 revealed she called and reported it to the Assistant Director of Nursing (ADON) #196 this same night, wrote a statement and placed it under ADON #196's door. Review of the staffing assignment forms from 05/21/25 through 06/04/25 revealed LPN #174 worked on unit one on 05/21/25, 05/22/25, 05/26/25, 05/27/25, 05/28/25, 06/03/25, and 06/04/25.Review of a statement dated 06/04/25 written by Registered Nurse (RN) #212 revealed on 06/04/25 around 7:20 P.M. she stopped in the 100 halls where LPN #174 was standing. RN #212 noticed at least four pill cups with Tylenol PM in them (blue pills with P525 on them). RN #212 stated to LPN #174, Wow you have that many people on Tylenol PM? and LPN #174 replied Yeah, I have a few and turned to give someone their medications. When LPN #174 returned to the cart, RN #212 stated she proceeded to take a picture of the pill cups on her cart. RN #212 stated she had seen LPN #174 prep her medications when she worked but had never got close enough to see what they were until tonight. RN #212 stated she immediately left and notified the Assistant Director of Nursing (ADON) #196 and sent her the pictures. Review of Resident #56's statement dated 06/05/25 taken by Former Interim Director of Nursing (FIDON) #800 revealed the resident was asked if she had been receiving Tylenol PM last night or anytime. Resident #56 stated she had not wished to answer and had not wanted to get anyone in trouble. Resident #56 stated she would like the nurse practitioner to be asked for an order for Tylenol PM because she needed it to help her sleep. FIDON #800 noted the resident had an order for Tylenol 325 milligrams and order for Melatonin 10 mg at bedtime. Review of a statement dated 06/05/25 by LPN #174 and emailed to FIDON #800 revealed she was off five days in a row and when she returned she had no clue what the new orders were. LPN #174 stated she always put Tylenol, Melatonin and Tylenol PM's in cups just in case there is a new order. LPN #174 also stated she pre-poured water cups before passing meds, so she was ready, it is available and easier. LPN #174 stated she was doing her medication pass last night at the nurses' station and RN #212 asked Is that Tylenol PM? Do you have that many orders for them? LPN #174 acknowledged what they were and kept on doing the medication pass. LPN #174 stated do I have time before med pass to check all the residents new orders to see if there are new orders for it, so I could not answer her second question. LPN #174 stated RN #212 walked away then came back with her phone out and took a picture of the medication cart and walked away. LPN #174 stated with that being said, lastly no Tylenol PM was given and the pills went back into the bottle at the end of my medication pass. Review of a statement dated