STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385132	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avamere Rehabilitation of King City	16485 SW Pacific Highway Tigard, OR 97224

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to provide an ongoing person-centered activity program for 3 of 3 sampled residents (#s 4, 5, and 20) reviewed for activities. This placed residents at risk for a decline in psychosocial well-being and diminished quality of life. Findings include:The facility's 11/2025 Activities Policy revealed the activities program was provided to support the well-being of residents and to encourage both independence and community interaction. The facility provided an activities program that addressed the intellectual, social, spiritual, creative, and physical needs, capabilities, and interests of each resident. 1. Resident 4 was admitted to the facility in 2021 with diagnoses including major depressive disorder and dementia. Resident 4's Activities Care Plan, revised on 7/11/25, indicated the following: -Resident 4 liked music, pet therapy, one-on-one conversations, reminiscing, stuffed animals, gardening, flowers, and birds. -Resident 4 was to have one-on-one bedside visits and activities to include music, animal visits, bird watching discussions, manicures, hand massages, and assistance looking through magazines. -Resident 4 was Christian, and the Activities Department was to provide gospel music. Resident 4's 10/15/25 Significant Change MDS revealed the resident had severe cognitive impairment. Her/his activity preferences indicated it was somewhat or very important to do her/his favorite activities, be around animals, and participate in religious services and practices. Resident 4's 11/4/25 through 12/4/25 Group Activity Task Log and One-On-One Activity Task Log contained no data regarding activity participation for one-on-one visits and one refusal on 12/1/25 for group participation. A review of Resident 4's electronic health record contained no evidence the resident participated in any activities. A review of the facility's activities calendar revealed five different activities each day between 8:30 AM and 6:00 PM From 12/1/25 through 12/4/25 Resident 4 was observed awake in her/his room with the blinds closed and not engaged in any activities on 9 occasions. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/4/25 at 10:19 AM Staff 24 (CNA) stated Resident 4 did not get out of bed, and she/he got confused when out of her/his room. Staff 4 stated she has not seen any activities occurring in Resident 4's room, and she was not aware of any one-on-one activities being done. Staff 24 stated Resident 4 would benefit from one-on-one activities. On 12/4/25 at 11:24 AM Staff 25 (CNA) stated Resident 4 spent her/his day in bed and would benefit from one-on-one activity visits. On 12/4/25 at 12:34 PM Staff 11 (Activities Director) stated she was the only person in the activities department, and was responsible for completing all care conferences, Activity MDS Assessments, Activities admission Profiles, shopping for residents, delivering mail, engaging residents in group and one-on-one person-centered activities, as well as assisting with many resident requests. She stated there was no one to provide activities on the weekends or when she was not in the facility. Staff 11 was unable to provide dates or times of any specific activities completed with Resident 4 and confirmed no activities documentation was completed. Staff 11 stated she did not have enough time to meet all residents' activity needs. On 12/5/25 at 8:41 AM Resident 4 stated she/he liked to look out of her/his window, listen to music, bird watch, and visit with pets. On 12/5/25 at 9:54 AM Staff 1 (Administrator) stated her expectations were that all residents received activities according to their person-centered care plan. Staff 1 stated she was actively recruiting for an additional activities assistant position. 2. Resident 20 admitted to the facility in 10/2025 with diagnoses including malignant neoplasm (cancerous tumor) of the brain. Resident 20's 10/16/25 admission Activity Profile, completed by Staff 11 (Activity Director) identified the resident was in the facility for Hospice/End of life care. Resident 20 enjoyed listening to music, family visits and reminiscing. Resident 20's 10/17/25 admission MDS assessed music was very important and it was somewhat to participate in religious services and/or practices and participate in her/his favorite activities. She/he was identified to have hospice services with a life expectancy of less than six months. On 12/3/25 at 8:24 AM and 10:50 AM Resident 20 was observed to lie in her/his dark room, no television or music playing, with eyes open and she/he was unresponsive to verbal stimuli. At 12:32 PM her/his family was visiting and Witness 9 (Family) stated the television was broken, and she/he had no music opportunities in the room. On 12/3/25 at 2:23 PM Staff 29 (CNA) stated they obtained the information to provide care including activities from the care plan. Resident 20 listened to music on her/his television and they took her/him to the activity room sometimes to listen to music. Staff 29 stated the Activity Director did not invite residents unless CNAs took the residents down to the activity room. On 12/4/25 at 12:08 PM Resident 20 was observed in her/his bed with family visiting. The family brought in a music device to listen to while they were visiting as the television still was not working and the facility did not provide any alternative way to listen to music. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A care plan dated 12/4/25 revealed Resident 20 was dependent on staff for participation in activities. Activities such as music, one on one visits, television and group activities were to be offered per the resident's choice and as tolerated. On 12/4/25 Resident 20's past 30 days of activity participation revealed no one on one visit were documented as offered and it was documented she/he attended three group activities. On 12/4/25 at 12:33 PM Staff 11 stated she was unaware Resident 20 received hospice services and confirmed she completed the Activity Profile which indicated hospice services were received upon admission. Staff 11 confirmed the lack of activity participation documentation for Resident 20 and acknowledged the group activity documented for 12/2/25 was an in-room pet visit by a volunteer. She was unable to express meaningful one on one visits with Resident 20 or engaging group activities. Staff 11 stated she was unaware Resident 20's television was broken as she did not see the resident this past week because she was too busy with everything to get to all residents. On 12/4/25 at 1:24 PM Witness 9 stated they were aware Resident 20 would sit in front of the television in the dining room while music played but no engagement or interactions occurred. On 12/5/25 at 10:42 AM Staff 1 (Administrator) stated she expected Resident 20 to be offered, as tolerated, resident centered, meaningful and engaging activities, especially since she/he was on hospice. Staff 1 expected all activities to be provided and documented. 3. Resident 5 admitted to the facility in 2020 with diagnoses including major depression. Resident 5's most recent Activity Profile assessment dated [DATE], identified her/his leisure interests as fishing, camping, outdoors, car shows, outdoor shows, radio with music from the past, reading horror and documentaries, card games, bingo game, mechanics, art, drawing, painting and bible studies. Resident 5's 8/26/25 Significant Change MDS assessed her/him to be cognitively intact with little interest or pleasure in doing things and feeling down. The Activity Preferences section identified the only activity preferences were to do her/his favorite activities and to go outside. On 12/3/25 at 8:27 AM, 10:20 AM, 12:40 PM, 2:43 PM and 12/4/25 at 10:11 AM Resident 5 was observed to lie in her/his bed, with a hat over her/his eyes in a dark, quiet room and not engaged in any diversional leisure activities. On 12/4/25 at 12:16 PM Staff 32 (CNA) stated Resident 5 did not participate in activities and she never saw the Activities Director interact with the resident. On 12/4/25 at 12:22 PM Resident 5 stated she/he asked for reading glasses several months ago and did not receive them. His room was observed not to have any reading books of horror or documentaries, and she/he stated she/he would read if the glasses and books were available. Resident 5 stated she/he could make her/his own leisure decisions but wanted access to more leisure items of interest to occupy her/his time as she/he was bored often. Resident 5 stated she/he did not get asked to attend groups, except for this week and even if she/he wanted to attend groups this week the November 2025 acalendar was still up in her/his room so she/he did not know the daily activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 5's 12/4/25 Care Plan directed staff to offer one on one activities, provide supplies to facilitate independent activities such as birdseed, squirrel food, gardening supplies and to sit outside. The 12/4/25 Activity Task for participation for the last 30 days revealed Resident 5 participated in no self-directed activities, no one on one activities and refused two groups activities. On 12/4/25 at 12:33 PM Staff 11 confirmed the lack of activity participation documentation. Staff 11 could not express Resident 5's offered opportunities of an ongoing resident centered activities program which incorporated the resident's interests, hobbies and cultural preferences which was integral to maintaining and/or improving the resident's physical, mental, and psychosocial well-being and independence. On 12/5/25 at 10:42 AM Staff 1 (Administrator) stated she expected Resident 5 to be offered and provided supplies for resident centered, meaningful and engaging activities.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review it was determined the facility failed to ensure residents were treated with dignity and respect for 1 of 1 sampled resident (#74) reviewed for dignity and respect. This placed residents at risk for lessened quality of life. Findings include:Resident 74 readmitted to the facility in 2024 with diagnoses including depression and anxiety.A 9/11/24 Facility Reported Incident indicated on 9/9/24 an incident between Resident 74 and Staff 9 (Former Medical Records) occurred outside in the garden area of the facility. Staff 8 (Housekeeping Manager) heard Staff 9 call Resident 74 a Goddamn fucking liar. The incident was witnessed by several residents and Staff 11 (Activities Director).The facility incident report indicated on 9/9/24 Resident 74 was outside in the garden. Resident 74 and Staff 9 were heard arguing about a plant that was allegedly uprooted and thrown in the garbage by the resident. Resident 74 denied the allegation and indicated another resident asked her/him to uproot the plant and move it to a different area for it to grow. The facility concluded staff 9 did not treat Resident 74 with dignity and respect. Facility interviews indicated the following:- Resident 74 indicated she/he was being blamed and was called a [NAME] by Staff 9. Resident 74 indicated she/he started the yelling because she/he was upset for being blamed for something she/he didn't do.- Staff 11 indicated she saw Staff 9 and Resident 74 yelling at each other over the plant. Staff 11 indicated Resident 74 insisted she/he did not throw the plant away and Staff 9 called the resident a liar. Staff 11 indicated heated words were exchanged between Staff 8 and Resident 74.- Staff 8 indicated she heard yelling in the garden area and heard Staff 9 call Resident 74 a goddamn fucking liar and went to de-escalate the situation. - Staff 9 denied calling Resident 74 a liar and indicated another resident called her/him a liar. Staff 9 indicated Resident 74 started yelling at her. Staff 9 indicated her voice may have been raised.On 12/2/25 at 10:23 AM Staff 11 stated the incident between Staff 9 and Resident 74 occurred in the garden area. Staff 11 stated she heard the resident and Staff 9 getting into an argument about plants being pulled and thrown away. Staff 11 stated she heard Staff 9 call Resident 74 a liar. Staff 11 stated it was inappropriate for Staff 9 to call the resident a liar and the incident was uncomfortable for everyone. Staff 11 stated she could not recall if profanities were used by Staff 9.On 12/2/25 at 10:25 AM Staff 8 stated the incident occurred outside in the garden. Staff 8 stated she heard Staff 9 say either shut the fuck up or shut the hell up to Resident 74. Staff 8 stated Staff 9 and Resident 74 were yelling at each other, and she went outside and told them both to calm down.On 12/4/25 at 9:01 AM Staff 9 stated another resident told her Resident 74 pulled out plants. Staff 9 stated she told Resident 74 that no one called her/him a liar. Staff 9 denied raising her voice and stated she used her mother tone with Resident 74 and only repeated back what Resident 74 had said, fucking liar.On 12/1/25 at 9:59 AM Staff 1 (Administrator) acknowledged the lack of dignity and respect occurred between Staff 9 and Resident 74 on 9/9/24.On 9/17/24 the facility provided information to indicate an action plan to prevent future occurrences was completed; audits, education and an in-service was completed related to treating resident with respect and dignity. The deficient practice was determined to be past non-compliance, corrected on 9/17/24.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review it was determined the facility failed to include and inform residents in advance of a change in pain medication for 1 of 1 sampled resident (#60) reviewed for pain. This placed the residents at risk for the inability to participate in their plan of care for pain management. Findings Include:Resident 60 admitted to the facility in 7/2025 with a diagnosis of Atherosclerosis (hardening of arteries) of left leg with rest pain.Resident 60's 7/15/25 Quarterly MDS indicated the resident was cognitively intact.Resident 60's 11/10/25 Physician Order indicated Resident 60's morphine was to be changed from TID to BID.Resident 60's health record revealed no evidence the decrease in morphine was discussed with the resident.A Progress Note dated 11/15/25 completed by Staff 20 (RN) indicated Resident 60 expressed frustration regarding recent medication changes and those changes were made without her/his consent.On 12/1/25 at 12:54 PM Resident 60 reported her/his morphine pain medication was recently reduced and reported she/he was not included in the decision.On 12/3/25 at 4:04 PM Staff 3 (LPN Resident Care Manager) reviewed Resident 60's health record and acknowledged that the resident was not included and informed in the decision to change the resident's pain medication.On 12/4/25 at 3:27 PM Staff 2 (DNS) was notified of the findings of this investigation. Staff 2 stated when a resident's pain medication was changed, the resident was to be included and informed.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, it was determined the facility failed to provide mobility bars as ordered for 1 of 1 sampled resident (#16) reviewed for accommodation of needs. This placed residents at risk for loss of ability to reposition independently. Findings include:Resident 16 was admitted to the facility in 1/2024 with diagnoses including type 2 diabetes mellitus. Resident 16's 8/5/25 physician order indicated the use of bilateral bed mobility bars.Resident 16's Care Plan, revised on 9/3/25, revealed bilateral mobility bars were to be used to increase resident participation with bed mobility.Resident 16's 11/2025 Annual MDS revealed Resident 16 was cognitively intact and required one-person assistance with mobility.Multiple observations from 12/1/25 through 12/4/25 between the hours of 11:01 AM to 3:33 PM revealed there was one mobility bar on the right side of Resident 16's bed.On 12/1/25 at 11:01 AM and 12/3/25 at 1:29 PM Resident 16 stated she/he was told she/he would have two mobility bars placed on her/his bed, but was only provided with one mobility bar. Resident 16 stated mobility bars would help her/him reposition herself/himself in bed.On 12/3/25 1:43 PM Staff 12 (CNA) stated Resident 16 used the mobility bar on her/his bed to assist with transfers and had only seen one mobility bar.On 12/4/25 at 10:32 AM Staff 24 (CNA) stated Resident 16 needed help adjusting herself/himself in bed when she/he was weak. Staff 24 stated the resident was care planned for one mobility bar according to Resident 16's Kardex (a system used by CNA staff to communicate important information).On 12/4/25 at 11:12 AM Staff 3 (LPN Resident Care Manager) confirmed Resident 16 was supposed to have two mobility bars on her/his bed.On 12/5/25 at 9:54 AM Staff 1 (Administrator) stated her expectation was Resident 16's care plan and physician orders for two mobility bars would be followed. Staff 1 confirmed Resident 16 only had one mobility bar on her/his bed.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review it was determined the facility failed to provide nonpharmacological interventions prior to the use of a PRN psychotropic medication and provide a rationale for indications for use of a PRN psychotropic medication for 1 of 5 sampled residents (#2) reviewed for unnecessary medications. This placed residents at risk for unnecessary psychotropic medication use and adverse side effects. Findings include:Resident 2 was admitted to the facility in 4/2025 with diagnoses including dementia. The resident's care plan for cognitive impairment, updated on 8/9/25, indicated behavioral disturbance and anxiety. Behavioral interventions included: assessing needs, creating a safe environment, offering activities, and reassuring the resident. The 10/9/25 Quarterly MDS identified Resident 2 was assessed to have no behaviors. Resident's 2's 11/2025 MAR revealed an order for PRN lorazepam (anti-anxiety) every four hours as needed for agitation, anxiety, restlessness, or nausea. The MAR indicated the PRN lorazepam was administered 20 times. No evidence or documentation was found in Resident 2's health record which demonstrated the use of nonpharmacological interventions prior to the administration of lorazepam, or a rationale for the use of lorazepam. From 12/2/25 through 12/5/25 between the hours of 8:42 AM and 3:15 PM the resident was observed to be in her/his room either in a wheelchair sleeping or awake and without behaviors. On 12/4/25 at 1:20 PM Staff 13 (CNA) reported Resident 2 occasionally had behaviors such as screaming or hitting at people but was easily redirected by watching television and drinking hot cocoa. On 12/4/25 at 1:39 PM Staff 32 (CNA) was able to identify strategies of giving hot cocoa and offering care choices as appropriate options for managing Resident 2's behaviors. Staff 32 said resident could be aggressive at times but was typically good natured. On 12/5/25 at 9:59 AM Staff 33 (CNA) identified Resident 2's behaviors occurred about twice per week when the resident wanted attention or hot cocoa. Staff 33 said the resident was redirected by putting on movies, braiding hair, or providing hot cocoa. On 12/5/25 9:49 AM Staff 19 (LPN) stated Resident 2's behaviors related to the use of lorazepam included yelling out if something was in her/his way, repeatedly asking for ice cream, and putting herself/himself on the floor. Staff 19 said the resident was redirected with music and watching DVDs. On 12/5/25 10:09 AM Staff 3 (LPN Resident Care Manager) said the expectation was for nurses to document each time behaviors occurred and resulted in the administration of PRN lorazepam. Staff 3 acknowledged the need for staff to utilize nonpharmacological interventions prior to administering PRN lorazepam.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review it was determined the facility failed to evaluate and manage increased pain after a pain medication change for 1 of 1 sampled resident (#60) reviewed for pain. This placed residents at risk for increased and unmanaged pain. Findings include:Resident 60 admitted to the facility in 7/2025 with a diagnosis of Atherosclerosis (hardening of arteries) of left leg with rest pain.Resident 60's 7/15/25 Quarterly MDS indicated the resident was cognitively intact, had almost constant pain and received scheduled and PRN pain medication.Resident 60's 10/17/25 Pain Care Plan included to attempt non-medication interventions prior to administration of pain medication, provide pain medications per the physician's orders, provide diversional activities, and to report complaints of pain to the nurse.The 10/17/25 Pain Evaluation specified Resident 60 received scheduled and PRN pain medication. The pain was reported as neuropathic, aching and burning in her/his lower back and left lower extremity. The pain was almost constant and was rated 7 out of 10 on the pain scale.Resident 60's 11/10/25 Physician Order indicated Resident 60's morphine changed from TID to BID.Progress Notes dated 11/11/25-12/4/25 noted Resident 60's complaints of increased pain. Resident 60 expressed concerns to staff that the pain was not adequately controlled and requested to speak with a provider.There was no documentation in Resident 60's health record to indicate the provider followed up regarding the ongoing pain complaints.On 12/1/25 at 12:54 PM Resident 60 reported her/his morphine pain medication was recently reduced and stated since the reduction she/he experienced increased phantom pain, restless leg symptoms, and difficulty sleeping. Resident 60 stated she/he reported increased pain to staff and asked to talk to the provider. Resident 60 stated the provider did not speak with her/him. Resident 60 was observed sitting up in bed and periodically rubbed her/his left leg.On 12/3/25 at 2:58 PM Staff 29 (CNA) reported Resident 60 complained of pain while using the bed pan or turning in bed.On 12/3/25 at 4:04 PM Staff 3 (LPN Resident Care Manager) reviewed Resident 60's health record and acknowledged Resident 60 complained of increased pain from 11/11/25 through 12/3/25. Staff 3 stated the provider was notified of the increased pain on 11/11/25. Staff 3 acknowledged there was no follow up after that date. Staff 3 stated she expected the increased pain to be addressed within a few days of the provider notification.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on interview and record review, it was determined the facility failed to comprehensively assess and develop mood and behavior interventions specific to expression of suicidal ideations for 1 of 1 sampled resident (#47) reviewed for behavioral/emotional health. This placed residents at risk for increased behaviors and a decline in psychosocial well-being. Findings include: The facility's 8/2025 Behavioral Health Services Policy revealed residents who exhibited signs of emotional/psychological distress received services and support to address their individual needs and goals for care.Resident 47 was admitted to the facility in 10/2025 with diagnoses including major depressive disorder. Resident 47's 10/11/25 hospital History and Physical Exam revealed Resident 47 had a diagnosis of suicidal ideations.Resident 47's 10/17/25 Social History Evaluation revealed Resident 47 stated she/he had a history of suicidal ideations.Resident 47's Care Plan dated 10/17/25 did not have interventions for suicidal ideations.On 12/1/25 at 9:51 AM Resident 4 stated she/he tried to commit suicide in the past and had suicidal thoughts occasionally since admission to the facility. Resident 4 stated, I have told them I am ready to go.On 12/4/25 at 10:03 AM Staff 24 (CNA) stated she was unaware of Resident 47's suicidal ideations. On 12/4/25 at 11:36 AM Staff 25 (CNA) stated Resident 47's mood and behaviors fluctuated and included dysregulation of mood, yelling, rude and sexual comments, and demanding behaviors. Staff 25 was unaware of Resident 47's suicidal ideations.On 12/4/25 at 1:37 PM Staff 10 (Social Services Director) stated she did not know Resident 47 had suicidal ideations. Staff 10 stated she reviewed the Social History Evaluation for Resident 47 but did not review it closely enough to notice the suicidal ideations mentioned in the evaluation. Staff 10 stated she would have referred Resident 47 to the facility's mental health provider right away, talked to family and Resident 47 about her/his suicidal ideations right away, and would have added care plan interventions immediately, if she knew about Resident 47's suicidal ideations. Staff 10 stated she did not speak with Resident 47 beyond one meeting regarding behaviors in therapy.On 12/4/25 at 1:51 PM Staff 28 (Social Services Coordinator) stated Staff 10 reviewed the Social History Evaluation before it was finalized. Staff 28 stated she noted suicidal ideations on Resident 47's 10/17/25 Social History Evaluation, but no follow-up occurred. She stated she did not speak to Resident 47 except for discharge planning.On 12/5/25 at 9:54 AM Staff 1 (Administrator) stated she expected residents with a diagnosis or statements of suicidal ideation to be immediately and comprehensively assessed the resident and determined what services were needed.

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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. Based on interview and record review it was determined the facility failed to ensure an account of all controlled drugs was maintained for 1 of 1 sampled resident (#2) reviewed for drug diversion. This placed residents at risk for drug diversion. Findings include:On 10/13/25 a FRI was received that indicated on 10/11/25 at 10:00 PM it was discovered that Resident 2 was missing methadone (narcotic medication). The facility investigation indicated on 10/12/25 two staff members counted narcotic medication at the end of their shift and found Resident 2 had 18 tablets of missing methadone. A staff member indicated she may have thrown away the medication. The facility was unable to locate the missing medicationThe 300 hall Controlled Substance Book number 29, page 108 revealed methadone had 18 tablets remaining on 10/11/25. There was no indication of the disposition of the remaining medication.On 12/4/25 at 8:24 AM Staff 12 (CMA) stated she worked a double shift on 10/11/25 and may have accidentally thrown the medication away. Staff 12 stated there were no discrepancies when counting with the oncoming CMA, Staff 23 (CMA) and they did not compare the narcotic pages to the narcotic cards.On 12/4/25 at 2:27 PM Staff 23 (CMA) stated she counted narcotics with Staff 12 on 10/11/25 and did not find a discrepancy because the narcotic pages were not compared with the narcotic cards.On 12/4/25 at 8:53 AM Staff 2 (DNS) acknowledged Resident 2 had 18 doses of methadone that were unaccounted for and Staff 12 and Staff 23 failed to reconcile narcotic medication.On 12/5/25 the facility provided information to indicate an action plan to prevent future occurrences was completed; audits, education and an in-service was completed related to controlled medication storage, controlled medication administration and abuse. The deficient practice was determined to be past non-compliance, corrected on 11/19/25.