STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425158	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ridgeway Manor Healthcare Center	117 Bellfield Road Ridgeway, SC 29130

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 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on interview, record review, and facility policy review, the facility failed to monitor, protect, and prevent misappropriation of narcotic medication for 1 of 3 residents (Resident (R)8) reviewed for misappropriation out of a total sample of 21 residents. This failure had the potential to place all residents receiving narcotic pain medication at risk of serious harm of uncontrolled pain due to drug diversion. Cross-Reference: F755 Pharmacy Services. The facility's failure to ensure prevention of misappropriation of property related to narcotic drug diversion had the potential to cause serious harm. Immediate Jeopardy was identified on 03/03/25 and was determined to exist on 02/26/25 in the area of S483.12 Misappropriation F602 at a scope and severity (S/S) of J. The Administrator was notified of the Immediate Jeopardy on 03/03/25 at 8:35 PM. The facility was notified that an acceptable plan of removal had been accepted on 03/04/25 at 7:38 PM. The survey team validated implementation of the removal plan through observations, staff interviews, and review of resident records and facility training records and the Immediate Jeopardy was removed on 03/05/25 at 1:50 PM. After removal of the Immediate Jeopardy, the deficiency remained at a D scope and severity for an isolated incident of potential harm. An extended survey was conducted in conjunction with the Recertification Survey for non-compliance at F602, constituting substandard quality of care. Findings include: Review of the facility's policy titled, Abuse, Neglect and Exploitation, revised 2024, revealed, . It is the policy of this facility to provide protections for the health. welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . 'Misappropriation of Resident property' means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent . Review of R8's Face Sheet, located in the resident's electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE], with diagnoses including but not limited to: breast cancer, chronic pain, major depressive disorder, affective mood disorder, and anxiety disorder. (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
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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 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R8's Quarterly Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/23/24, and located in the Aspen MDS viewer, revealed R8 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact. It was recorded R8 received scheduled and as needed (PRN) pain medications, stated her pain was moderate, and occasionally affected her sleep. It was recorded R8 stated she occasionally had pain. Review of R8's Order Summary, located under the Orders tab of the EMR, revealed on 01/30/25, R8 had physician orders for oxycodone, a narcotic pain medication, five (5) milligrams (mg) one tablet every four hours while awake. Review of R8's narcotic count sheets, provided by the facility and dated 01/30/25, revealed R8 received six blister packs of oxycodone 5mg, with each pack containing 30 tablets, for a total of 180 tablets. Review of a Prescriptions Delivered to [NAME] Manor sheet, provided by the facility, revealed 180 tablets of oxycodone 5mg were delivered for R8 at 1:47 PM on 01/30/25. Review of R8's Medication Administration Records (MARs), dated 01/30/25 and 01/31/25, and located under the Orders tab of the EMR, revealed documentation indicating R8 received a total of eight oxycodone 5mg tablets from 4:00 PM on 01/30/25 through 8:00 PM on 01/31/25. Review of R8's MARs, dated 02/01/25 through 02/21/25 at 12:00 PM, revealed R8 received one oxycodone 5mg tab every four hours while awake a total of 115 tabs (eight times documented as asleep, one time documented as other see progress notes). It was recorded that R8's order was changed to oxycodone 5mg one tab twice daily on 02/21/25, and R8 received 10 oxycodone 5mg tablets from 02/21/25 at 9:00 PM through 02/26/25 at 9:00 AM. This was a total of 133 oxycodone 5 mg tablets R8 received from 02/01/25 through 02/26/25 at 9:00 AM. Review of R8's Controlled Medication Utilization Record [narcotic count sheet], dated 02/25/25, revealed two oxycodone 5mg tablets were destroyed. Review of R8's clinical record revealed no documentation as to when administration of the oxycodone tablets delivered on 01/30/25 was started. If the administration was started on 01/30/25 at 4:00 PM (after the medications were delivered at 1:47 PM), a total of 133 tablets were administered per documentation, leaving 47 tablets. Two tablets were destroyed on 02/25/25, which would leave 45 tablets. There was no documentation of administration of these 45 tablets. Review of the narcotic count sheets showed that R8 received the medications from blister pack number 2 on 02/03/25 through 02/09/25. It was recorded R8 received the medications from blister pack number 3 on 02/09/25 through 02/14/25. There were no narcotic count sheets for blister packs number 1, 4, 5, or 6. Review of a facility investigative file revealed the following: (continued on next page)

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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 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Statement from Registered Nurse (RN)1, dated 02/26/25, documented . On Monday, February 24th, I commenced my employment at Ridegeway Manor. My understanding was that [R8]'s prescription for oxycodone 5mg was [every four hours] PRN pain. On Tuesday, February 25th, [LPN1] brought to my attention a discrepancy in [R8]'s medication orders. A review revealed that the prescription had been altered on February 21st, changing [R8]'s oxycodone regimen to twice daily . for a five-day period (February 21st -27th). This change, while documented in the electronic medical record, was not accurately reflected in the hard-copy narcotics book . [LPN1] identified the discrepancy on Tuesday morning. Following this, my manager [Unit Manager (UM)] and I reconciled [R8]'s medication record. A corrected medication administration record (MAR) was created and placed in the narcotics book to prevent further errors. A total of six oxycodone 5gm [sic] tablets accounted for. Three of the six oxycodone 5mg tablets were secured. One tablet was dispensed for [LPN1]'s 9 PM shift, leaving two tablets for the morning and evening of February 26th. However, following shift change and after reconciliation with [LPN1], an additional decided to waste the other two tablets. [LPN1] and I signed a documented account of this discrepancy which was then placed in the designated management review folder. The discrepancy was rectified following review of this report . Statement from LPN1, dated 02/26/25, documented . On 02/25/25 I relieved 7a-7p nurse when I opened the narcotic box I saw a pill pack with 3 small pills in it. The nurse informed me that the pills were for resident in [R8's room]. She showed me the narcotic sheet that it belong [sic] to. I informed the nurse that we had to waste those pills. I did use the 9p dose and she and I wasted the 9a and 1p dose. When my 7a-7p nurse came and we counted the narcotic box she asked where were [sic] [R8]'s oxycodone I informed her that we wasted the pills and that she could get the card from the unit manager . Statement from LPN2, dated 02/26/25, documented . When I came in this am, I was counting with [LPN1]. I asked where is [R8]'s oxys [oxycodone]. She said girl you don't want to know. She then tells me that when she came in last night the off going nurse showed her a pill crusher pouch with 2 or 3 pills in it [and] states [UM] said that was [R8]'s oxy for tonight [and] in the morning. [LPN1] said she did not feel comfortable with that [and] she wanted to waste them in which they did. Off going nurse then texted [UM] to let her know. I had to go to [UM] to get this mornings [sic] dose. She brought me the card [and] punched out one oxy for me to give this am and said I'll sign it out. She then said she was keeping them in her office because some of the nurses where [sic] giving the 4xday order instead of holding like the order stated for 4 days. She said she was going to run out of oxy if that kept going on, she . took meds back to her office . Review of a Facility Reported Incident report, dated 02/26/25, revealed, . The Narcotic count for [R8] was not correct. The Director of Nursing (DON) contacted the pharmacy to verify the last date of delivery and count filled. Based on the information provided and number of pills on hand, it was determined that medications were likely missing. The Unit Manager (UM), was asked to come to the DON's office to discuss this issue and instead of coming to the office she left the facility grounds and quit. The Administrator contacted the UM and informed her that they were investigating the missing medications and that is when the UM informed them that she quit. She returned to the facility and gave her statement and produced a blister pack of [R8]'s oxycodone with two pills left in it that she had in her possession. Local County Sheriff department notified . (continued on next page)

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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 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/01/25 at 6:43 PM, Registered Nurse (RN) 1 stated that on 02/25/25, The [UM] gave me three pills in a plastic crush pouch. She told me one was for 9:00 PM that night for [R8], and the other two were for 9:00 AM and 1:00 PM tomorrow. I think there were around 14-16 pills left because if you add up the dosages according to her medication administration record (MAR), then that would account for the discrepancy and add up to her old oxycodone order. During an interview on 03/02/25 at 10:50 AM, R8 stated she took pain medication. R8 stated, I don't know if I get them all or not unless I start hurting, but I'm hurting all the time it seems. I can only take bed baths. Sometimes it's just too painful to take a shower. R8 stated, I have caner in the brain, have breast cancer, but now it's all over and in my brain, so I can't remember some things now. During an interview on 03/02/25 at 3:56 PM, the Director of Nursing (DON), stated, I was made aware [of the incident on 02/25/25] when the day shift [LPN] informed me the night shift nurse told her of the incident with the medication of three pills in a plastic crush bag. She told me she didn't have any oxycodone for the resident. I let the Administrator know and report it to the local sheriff department. [UM] returned to the facility, attempted to go into her office, but it was locked, and then pulled a blister pack containing two pills from her purse and turned them in. I did a narcotic reconciliation on all the carts and educated day shift on making sure that the narcotic book always matched the MAR and to only give meds according to what the MAR says and not the narcotic book because sometimes the pink change stickers don't get put on the narcotic sheets and they give the wrong dose. We also educated them on never removing narcotics from their med cart, always keeping the narcotic sheets in the narcotic book, and never give your keys up to anyone. The Administrator had to leave for an appointment, but I kept her updated via text. The Regional Clinical Director arrived and reported it to the state. During an interview on 03/02/25 at 4:43 PM, the DON stated, I have an issue with the statement that [RN1] wrote. She told me she saw on the blister pack [R8]'s name and the medication name but did not see how many pills were left. I don't know how many pills were missing and that UM returned the blister pack with two pills remaining. During a telephone interview on 03/03/25 at 2:35 PM, local County Sheriff Sergeant stated, I filed two warrants for her [UM] arrest, I do not know if she has turned herself in. I've done my part of the investigation. The County Sheriff Sergeant stated, Facility staff told me the 14 pills were missing. I took pictures [of the blister pack] and gave them back. According to the police report, there is a discrepancy of 14 oxycodone pills missing. During an interview on 03/03/25 at 2:50 PM, the Administer stated, We can't provide the other blister packs or narcotic sheets, because they are missing. The DON told me she discovered it during the investigation. We don't know what happened to them. The entire blister packs of pills are missing. During an interview on 03/03/25 at 3:40 PM, the DON stated, No that's incorrect, we are not missing any narcotic blister packs. They were all given. We are just missing the narcotic sheets. The UM took the one narcotic sheet, but we don't know where the others are or who took them. We don't have the blister packs so they were given and all I can say is that the narcotic sheets are missing. The DON was not able to answer how she knew the oxycodone was given if she did not have the narcotic sheets to show they were given. The DON responded, because it says they were in the electronic medical record (EMR). (continued on next page)

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F 0602 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 03/03/25 at 4:15 PM, the Administrator reported that she was incorrect in her statement that there were missing narcotics. She stated just the narcotic sheets were missing. On 03/04/25 at 7:38 PM, the facility submitted an acceptable removal plan, which included the following: The resident's medications were replaced and the MAR show's no doses of the medication were missed. An audit of all narcotic medications and controlled substance count forms was conducted on 3/2/25. No other issues were identified. Policies and procedures were reviewed on 3/3/25 to identify any necessary revisions to aid in control of narcotic diversion. The facility reported the nurse to LLR on 3/2/25. F602 does not state the time frame for reporting to LLR. On 2/6/25 education for all staff was initiated on resident abuse, neglect, and misappropriation of property. This education includes the need for immediate reporting of suspicious behavior in relation to narcotic medications and is being provided to staff from all shifts and PRN and agency staff as well and will be conducted prior their next shift. This education will be completed on or before 3/5/25. All new hires will receive this education during their orientation, prior to resident contact. Policies and procedures were reviewed by the Admin, DON, RDO, and RNC, on 3/3/25 to identify any necessary revisions to aid in control of narcotic diversion. As a result of the review updates on the narcotic count sheet process and accounting were revised on the policy tilted Controlled Substance Administration and Accountability. These changes included updating of the how the total number of meds is noted on the sheets and it now requires two nurses' signatures to add or removed medications. The diverted medications were identified as actually missing at approx. 3pm on 2/26/25 and the 2-hour report was sent to the state agency at 4:57 pm which was within the 2-hour window. All reportable events will be reviewed monthly by the QAPI Committee to ensure timely reporting is accomplished. The facility reported the nurse to LLR on 3/2/25. F602 does not state the time frame for reporting to LLR. All allegations requiring reporting to LLR will be reported with the initial report to the state agency hence forth. The controlled substance card count sheet was updated to include a full count off on hand medications. With two nurse's signatures required to add or remove medications from the cart. The DON and/or Admin will audit narcotic counts and medications will be conducted three times weekly until no further instances of non-compliance are found to exist. Once compliance is achieved the audits will be conducted weekly going forward. All audit results will be provided the facility QAPI committee for review. The facility QAPI committee will review the narcotic count audits monthly times three months of audits showing no issues. All reportable events will be reviewed monthly by the QAPI Committee to ensure timely reporting is accomplished.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on review of the facility policy, record review and interviews, the facility failed to report an allegation of misappropriation of narcotic medication to the state survey agency within two hours for 1 of 3 residents (Resident (R)8) reviewed for abuse out of a total sample of 21 residents. This had the potential to allow continued misappropriation. Findings include: Review of the facility's policy titled, Abuse, Neglect and Exploitation, revised 2024, revealed, . It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property . Misappropriation of Resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent, use of a resident's belongings or money without the resident's consent . Reporting / Response. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury . Review of R8's Face Sheet located in resident's electronic medical record (EMR) under the Profile tab, revealed, R8 was admitted to the facility on [DATE], with diagnoses including but not limited to: left breast cancer, chronic pain, major depressive disorder, affective mood disorder and anxiety disorder. Review of a Facility Reported Incident report, dated 02/26/25, revealed, . The Narcotic count for [R8] was not correct. The Director of Nursing (DON) contacted the pharmacy to verify the last date of delivery and count filled. Based on the information provided and number of pills on hand, it was determined that medications were likely missing. The Unit Manager (UM) was asked to come to the DON's office to discuss this issue and instead of coming to the office she left the facility grounds and quit. The Administrator contacted the UM and informed her that they were investigating the missing medications and that is when the UM informed them that she quit. She returned to the facility and gave her statement and produced a blister pack of [R8]'s oxycodone with two pills left in it that she had in her possession. Local County Sheriff department notified . (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/02/25 at 3:56 PM, the Director of Nursing (DON) stated, I found out at 8:50 AM [on 02/26/25] from [Licensed Practical Nurse (LPN)2] about the drug diversion and missing oxycodone and told the Administrator right before the 9:00 AM morning meeting. We finished the morning meeting and started investigating. We had pharmacy come in and destroy drugs with us while they were here. The [Unit Manager (UM)] was doing care plan meetings in the MDS office. The Administrator called her down to come meet. The MDS told the Administrator the UM was not there. The Administrator asked Human Resources [HR] to try to track her down. The Administrator looked at the parking lot and saw that the [UM]'s car was no longer in the parking lot. So, the Administrator and I went into the [UM]'s office and found her nurse keys lying on top of the desk. We searched through her desk and office and the med cart. HR tried calling the [UM] on her cell phone and she didn't answer. [UM] called her back and asked, What do you want? HR asked her if she was at the facility. The [UM] responded, No I am not, and you people are full of 'bleep' and hung up. I called [UM] back and asked her where the missing narcotics were, and the missing narcotic sheets were and let her know we had already searched her office and didn't find anything. We asked her to come back to the facility. The Regional Corporate Director [RCD] arrived. Then the [UM] arrived and went straight to her office to try to get into it, but she left her keys earlier and was not able to. The [UM] handed me a blister card pack with two oxycodone pills from her purse and then left. The RCD called the local law enforcement to report it around 11:30 AM and possibly press charges. Law enforcement arrived. We kept the Administrator aware of everything via texts and calls. During an interview on 03/02/25 at 5:14 PM, the Administrator stated, It started Wednesday morning when [LPN2], the day shift nurse went to the DON and reported the missing narcotics to her right after meeting. The UM was in care plan meeting in the MDS office, and I called her around 11:00 AM to ask her to come to the office and talk with me. She never came. I called her again. The MDS nurse said she left. I had Human Resources try to contact her on her cell phone. I had a Dr. appointment and had to leave the building and couldn't follow up, but the staff kept in contact with me via phone calls and text to update me. During an interview on 03/04/25 at 4:52 PM, LPN2 stated, Between 8:00 AM and 8:30 AM, I let the [UM] know that I was out of [R8]'s oxycodone and needed more. The [UM] returned from her office with a blister pack of meds. She popped out one pill and I saw the blister pack had [R8]'s name on it and what the med was, but I didn't see how many meds were on the card. I didn't think this was the right way to handle narcotics and I reported it to the DON when she came in that morning before the morning meeting. During an interview on 03/05/25 at 12:25 PM, the Administrator stated, We didn't report it to the state until we validated that drugs were missing and that took until 3:00 PM when the RCD reported it. We don't report anything until we know for sure there is something to report, otherwise we would be reporting every little thing. During an interview on 03/05/25 at 5:25 AM, the DON stated, We didn't call into the state, because there was nothing to report until 3:00 PM. We didn't know she took anything or that anything was wrong until 3:00 PM.

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on interviews, and facility policy review, the facility failed to use nursing rights of medication administration while administrating a medication for 1 of 21 residents (Resident (R)8), reviewed for professional standards. This failure had the potential for residents being subject to adverse effects leading to worsening symptoms, long-term effects, and death. Findings include: Review of the facility's policy titled, Medication Administration revised 2022, revealed, . Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time. a. Refer to drug reference if unfamiliar with the medication, including its mechanism of action or common side effects . Review of R8's Face Sheet, located in resident's electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE], with diagnoses which included but was not limited to: left breast cancer, chronic pain, major depressive disorder, affective mood disorder, and anxiety disorder. Review of R8's Quarterly Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 12/23/24, and located in the Aspen MDS viewer, revealed R8 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. Review of R8's Order Summary located in resident's EMR under the Orders tab, revealed that on 02/25/25, R8 had physician's orders for oxycodone five milligrams (mg) one tablet twice daily for pain. Review of a facility investigative file for R8 revealed the following: Statement from Registered Nurse (RN)1, dated 02/26/25 - . On Tuesday, February 25th, [Licensed Practical Nurse (LPN)1] brought to my attention a discrepancy in [R8]'s medication orders. A review revealed that the prescription had been altered on February 21st, changing [R8]'s oxycodone regimen to twice daily . for a five-day period (February 21st -27th. This change, while documented in the electronic medical record, was not accurately reflected in the hard-copy narcotics book . [LPN1] identified the discrepancy on Tuesday morning. Following this, my manager [Unit Manager (UM)] and I reconciled [R8]'s medication record. A corrected medication administration record (MAR) was created and placed in the narcotics book to prevent further errors. A total of six oxycodone 5gm [sic] tablets accounted for. Three of the six oxycodone 5mg tablets were secured. One tablet was dispensed for [LPN1]'s 9 PM shift, leaving two tablets for the morning and evening of February 26th. However, following shift change and after reconciliation with [LPN1], an additional decided to waste the other two tablets. [LPN1] and I signed a documented account of this discrepancy which was then placed in the designated management review folder. The discrepancy was rectified following review of this report . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Statement from LPN1, dated 02/26/25 - . On 02/25/25 I relieved 7a-7p nurse when I opened the narcotic box I saw a pill pack with 3 small pills in it. The nurse informed me that the pills were for resident in [R8's room]. She showed me the narcotic sheet that it belong [sic] to. I informed the nurse that we had to waste those pills. I did use the 9p dose and she and I wasted the 9a and 1p dose. When my 7a-7p nurse came and we counted the narcotic box she asked where were [sic] [R8]'s oxycodone I informed her that we wasted the pills and that she could get the card from the unit manager . During an interview on 03/02/25 at 6:43 PM, Registered Nurse (RN)1 stated, The Unit Manager gave me three pills in a plastic crush pouch that I watched her pop out of the blister pack. She told me one was for 9:00 PM that night for [R8], and the other two were for 9:00 AM and 1:00 PM tomorrow. During an interview on 03/05/25 at 10:19 AM, LPN1 stated, The pill in the plastic crush pouch looked like an Oxycodone. [RN1] told me it was during shift change. If I didn't give it to R8, then she wouldn't have had any pain meds that night. We have a drug reference library on our electronic medical record (EMR) that we can use to look up a med is, but I did not use it for that pill. During an interview on 03/05/25 at 10:45 AM, the DON stated, I would expect that a nurse never give medication that they did not pop out of the blister pack themselves. They must know what they are giving. During an interview on 03/05/25 at 10:46 AM, the Administrator stated, I agree with the DON. No nurse should give medication that they didn't pull themselves. There is no way that nurse should have given that med.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 11599 Based on record review and interview, the facility failed to ensure Registered Nurse coverage was provided eight hours a day seven days a week for a total of seven days in July, August, and September 2024. The failure created the potential for the clinical needs of all residents not to be met. Findings include: Review of the facility's Job Description: Registered Nurse, provided by the Regional Director of Operations (RDO) noted, SUMMARY Assesses and evaluates the health status of resident/patient and provides care and treatment in accordance with physician orders and standards of practice. ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned Assesses patients by physical examination including pertinent diagnostic testing to determine health status. Administers medications and treatments. Participates in the care planning process and oversees implementation of the plan. Supervises LPNS [Licensed Practical Nurses] and Nursing Assistants. Oversees ADLS [activities of daily living] and documentation. Communicates with physicians regarding changes in conditions, diagnostic test results, etc. Documents assessments and care in compliance with standards of care and company policy. Educates patients and their families on health-related issues. The facility was licensed for a total of 112 beds. Review of the Payroll Based Journal (PBJ) from the fourth quarter of 2024 revealed the following dates had no Registered Nurse (RN) coverage: 07/06/24, 07/17/24, 07/20/24, 07/21/24, 08/18/24, 08/22/24, and 09/01/24. Review of the Daily Census Reports, provided by the Staffing/Medical Supplies (SMS) for the identified dates revealed the census was 99, 101, 100, 99, 97, 96, and 93, respectively. During an interview on 03/03/25 at 3:47 PM, both the SMS and the Human Resources Director (HRD), responsible for submitting the PBJ information, confirmed there was no RN coverage for the identified dates. In an interview on 03/04/25 at 12:47 PM, the Administrator and Director of Nurses confirmed there was no RN coverage for the seven identified dates in 2024. In an interview on 03/05/25 at 1:19 PM, the Regional Director of Operations (RDO) confirmed there was no RN coverage for the seven identified dates in 2024.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43353 Based on interview, record review, and facility policy review, the facility failed to provide and maintain pharmaceutical services for the receipt, disposition, reconciliation, and control of narcotic medication for 1 of 3 residents (Resident (R)8) reviewed for medications out of a total sample of 21 residents. This failure had the potential to place all residents receiving narcotic pain medication at risk of serious harm of uncontrolled pain due to drug diversion. Cross Reference: F602 Misappropriation. The facility's failure to ensure pharmaceutical services were provided to meet the needs of each resident had the potential to cause serious harm. Immediate Jeopardy was identified on 03/03/25 and was determined to exist on 02/26/25, in the area of S483.45 Pharmacy Services F755 at a scope and severity (S/S) of J. The Administrator was notified of the Immediate Jeopardy on 03/03/25 at 8:35 PM. The facility was notified that an acceptable plan of removal had been accepted on 03/04/25 at 7:38 PM. The survey team validated implementation of the removal plan through observations, staff interviews, and review of resident records and facility training records and the Immediate Jeopardy was removed on 03/05/25 at 1:50 PM. After removal of the Immediate Jeopardy, the deficiency remained at a D scope and severity for an isolated incident of potential harm. Findings include: Review of the facility's policy titled, Medication Administration, revised 2022, revealed, . Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . Review of R8's Face Sheet located in resident's electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE], with diagnoses which included breast cancer, chronic pain, major depressive disorder, affective mood disorder, and anxiety disorder. Review of R8's quarterly Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 12/23/24 and located in the Aspen MDS viewer, revealed R8 scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident was cognitively intact. It was recorded R8 received scheduled and as needed (PRN) pain medications, stated her pain was moderate, and occasionally affected her sleep. It was recorded R8 stated she occasionally had pain. Review of R8's Order Summary, located under the Orders tab of the EMR, revealed on 01/30/25, R8 had physician orders for oxycodone, a narcotic pain medication, five (5) milligrams (mg) one tablet every four hours while awake. Review of R8's narcotic count sheets, provided by the facility and dated 01/30/25, revealed R8 received six blister packs of oxycodone 5mg, with each pack containing 30 tablets, for a total of 180 tablets. Review of a Prescriptions Delivered to [NAME] Manor sheet, provided by the facility, revealed 180 tables of oxycodone 5mg were delivered for R8 at 1:47 PM on 01/30/25. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R8's Medication Administration Records (MARs), dated 01/30/25 and 01/31/25 and located under the Orders tab of the EMR, revealed documentation R8 received a total of eight oxycodone 5mg tablets from 4:00 PM on 01/30/25 through 8:00 PM on 01/31/25. Review of R8's MARs, dated 02/01/25 through 02/21/25 at 12:00 PM, revealed R8 received one oxycodone 5mg tab every four hours, for a total of 115 tabs (eight times documented as asleep, one time documented as other see progress notes). It was recorded that R8's order was changed to oxycodone 5mg one tab twice daily on 02/21/25, and R8 received 10 oxycodone 5mg tablets from 02/21/25 at 9:00 PM through 02/26/25 at 9:00 AM. This was a total of 133 oxycodone 5 mg tablets R8 received from 02/01/25 through 02/26/25 at 9:00 AM. Review of R8's Controlled Medication Utilization Record [narcotic count sheet], dated 02/25/25, revealed two oxycodone 5mg tablets were destroyed. Review of R8's clinical record revealed no documentation as to when administration of the oxycodone tablets delivered on 01/30/25 was started. If the administration was started on 01/30/25 at 4:00 PM (after the medications were delivered at 1:47 PM), a total of 133 tablets were administered per documentation, leaving 47 tablets. Two tablets were destroyed on 02/25/25, which would leave 45 tablets. There was no documentation of administration of these 45 tablets. Review of the narcotic count sheets showed that R8 received the medications from blister pack number 2 on 02/03/25 through 02/09/25. It was recorded R8 received the medications from blister pack number 3 on 02/09/25 through 02/14/25. There were no narcotic count sheets for blister packs number 1, 4, 5, or 6. Review of a Facility Reported Incident report, dated 02/26/25, revealed, . The Narcotic count for [R8] was not correct. The Director of Nursing (DON) contacted the pharmacy to verify the last date of delivery and count filled. Based on the information provided and number of pills on hand, it was determined that medications were likely missing. The Unit Manager (UM), was asked to come to the DON's office to discuss this issue and instead of coming to the office she left the facility grounds and quit. The Administrator contacted the UM and informed her that they were investigating the missing medications and that is when the UM informed them that she quit. She returned to the facility and gave her statement and produced a blister pack of [R8]'s oxycodone with two pills left in it that she had in her possession. Local County Sheriff department notified . During an interview on 3/01/25 at 6:43 PM, Registered Nurse (RN) 1 stated that on 02/25/25, The UM gave me three pills in a plastic crush pouch. She told me one was for 9:00 PM that night for R8], and the other two were for 9:00 AM and 1:00 PM tomorrow. I think there were around 14-16 pills left because if you add up the dosages according to her medication administration record (MAR), then that would account for the discrepancy and add up to her old oxycodone order. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 3/02/25 at 3:56 PM, Director of Nursing (DON), stated, I was made aware [of the potential drug diversion] [on 02/26/25] when the day shift [Licensed Practical Nurse] informed me the night shift nurse told her the incident of the medication of 3 pills in a plastic crush bag. She told me she didn't have any oxycodone for the resident. I let the Administrator know and report it to the local sheriff department. [UM] returned to the facility, attempted to go into her office, but it was locked, and then pulled a blister pack containing two pills from her purse and turned them in. I did a narcotic reconciliation on all the carts and educated day shift on making sure that the narcotic book always matched the MAR and to only give meds according to what the MAR says and not the narcotic book because sometimes the pink change stickers don't get put on the narcotic sheets and they give the wrong dose. We also educated them on never removing narcotics from their med cart, always keeping the narcotic sheets in the narcotic book, and never giving your keys up to anyone. Continuing with the interview on 03/02/25 at 3:56 PM, the DON stated, No we don't require two nurses to put narcotics away or remove them from the med cart. We don't need two nurses to sign off on them to put them in the DON office because they are locked up and no one touches them. We don't need to reconcile them because again, no one touches them. The DON stated that the UM should not have been removing them and taking them to her office, so no double signature would have been needed. During an interview on 3/02/25 at 4:43 PM, Director of Nursing (DON), stated, I have an issue with the statement that [Registered Nurse 1] wrote. She told me she saw on the blister pack [R8]'s name and the medication name, but did not see how many pills were left. I don't know how many pills were missing and that [UM] returned the blister pack with two pills remaining. During an interview on 03/03/25 at 12:30 PM, the Pharmacy Technician (PT) stated that when narcotic medications were delivered to the facility, the nurse would take the medications to her cart and put them away. The PT stated the signature of two nurses was not required for the receipt of narcotic medications. During a telephone interview on 3/03/25 at 2:35 PM, the local County Sheriff [NAME] stated, Facility staff told me the 14 pills were missing. I took pictures [of the blister pack]and gave them back. According to the police report there is a discrepancy of 14 oxycodone pills missing. During an interview on 3/03/25 at 2:50 PM, the Administer stated, We can't provide the other blister packs or narcotic sheets, because they are missing. The DON told me she discovered it during the investigation. We don't know what happened to them. The entire blister packs of pills are missing. During an interview on 3/03/25 at 3:40 PM, Director of Nursing (DON), stated, No that's incorrect, we are not missing any narcotic blister packs. They were all given. We are just missing the narcotic sheets. The UM took the one narcotic sheet, but we don't know where the other sheets are or who took them. We don't have the blister packs so they were given and all I can say is that the narcotic sheets are missing. The DON was not able to answer how she knew the oxycodone was given if she did not have the narcotic sheets to show they were given. She responded because it says they were in the electronic medical record (EMR). On 03/03/25 at 4:15 PM, the Administrator reported that she was incorrect in her statement that there were missing narcotics. She stated just the narcotic sheets were missing. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 03/04/25 at 4:52 PM, Licensed Practical Nurse (LPN) 2 stated that when she arrived on 02/26/25 and completed the narcotic count with LPN1, she had asked where R8's oxycodone were. LPN2 stated LPN1 had told her the UM had brought three oxycodone tablets from her office and placed them in the medication cart in a pill crusher pouch for R8 to have for the evening dose on 02/25/25 and the two doses for 02/26/25. LPN2 stated LPN1 told her she had destroyed two of the pills (with a witness) because she was uncomfortable with the situation. LPN2 stated she went to the UM to obtain R8's morning dose of oxycodone, and the UM had told her she would bring it to her. LPN2 stated the UM came about 10 minutes later with a medication card in her hand and punched the medication. LPN2 stated the UM told her she had the narcotic count sheet in her office and she would bring the sheet to her to sign off for the medication. On 03/04/25 at 7:38 PM, the facility submitted an acceptable removal plan, which included the following: The resident's medications were replaced and the MAR show's no doses of the medication were missed. An audit of all narcotic medications and controlled substance count forms was conducted on 3/2/25. No other issues were identified. Policies and procedures were reviewed on 3/3/25 to identify any necessary revisions to aid in control of narcotic diversion. The facility reported the nurse to LLR on 3/2/25. F602 does not state the time frame for reporting to LLR. On 2/6/25 education for all staff was initiated on resident abuse, neglect, and misappropriation of property. This education includes the need for immediate reporting of suspicious behavior in relation to narcotic medications and is being provided to staff from all shifts and PRN and agency staff as well and will be conducted prior their next shift. This education will be completed on or before 3/5/25. All new hires will receive this education during their orientation, prior to resident contact. Policies and procedures were reviewed by the Admin, DON, RDO, and RNC, on 3/3/25 to identify any necessary revisions to aid in control of narcotic diversion. As a result of the review updates on the narcotic count sheet process and accounting were revised on the policy tilted Controlled Substance Administration and Accountability. These changes included updating of the how the total number of meds is noted on the sheets and it now requires two nurses' signatures to add or removed medications. The diverted medications were identified as actually missing at approx. 3pm on 2/26/25 and the 2-hour report was sent to the state agency at 4:57 pm which was within the 2-hour window. All reportable events will be reviewed monthly by the QAPI Committee to ensure timely reporting is accomplished. The facility reported the nurse to LLR on 3/2/25. F602 does not state the time frame for reporting to LLR. All allegations requiring reporting to LLR will be reported with the initial report to the state agency hence forth. The controlled substance card count sheet was updated to include a full count off on hand medications. With two nurse's signatures required to add or remove medications from the cart. The DON and/or Admin will audit narcotic counts and medications will be conducted three times weekly until no further instances of non-compliance are found to exist. Once compliance is achieved the audits will be conducted weekly going forward. All audit results will be provided the facility QAPI committee for review. The facility QAPI committee will review the narcotic count audits monthly times three months of audits showing no issues. All reportable events will be reviewed monthly by the QAPI Committee to ensure timely reporting is accomplished.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40824 Based on observations, interviews, and record review, the facility failed to ensure food stored in the main kitchen was labeled and dated. The failures had the potential to increase the prevalence and spread of foodborne illness and infection for 79 residents who receive food from the kitchen. 6 residents receive tube feedings with no food/fluids provided by the kitchen. Findings include: Review of the facility's undated policy titled, Food Storage stated Sufficient storage facilities are provided to keep foods safe . and by methods designed to prevent contamination . Rewrap packages of frozen food which have been opened. This prevents freezer burns and spoilage . Review of the facility's policy dated 02/2023 titled, Food Safety Requirements stated, . Food will also be stored . in accordance with professional standards for food service safety . Food safety practices shall be followed throughout the facility's entire food handling process . Storage of food in a manner that helps prevent deterioration or contamination of food, including from growth of organisms . Labeling, dating, and monitoring refrigerated foods . Keeping foods covered or in tight containers . During an observation on 03/02/25 at 9:15 AM, of food storage in the meat freezer revealed an undated, opened bag of chicken tenders stored in a clear bag that was tied in a knot for closure. The use by date on the bag read 01/08/25. An undated clear bag containing fish fillets stored in a clear bag that was tied in a knot for closure was also observed. There was no use by date on the bag, no received date, and no date opened. Ice crystals were noted on the fillets. An opened brown bag of frozen French fries was observed with no opened date, no received date, and no use by date. The bag was rolled up and not securely closed. During an interview on 03/02/25 at 9:15 AM, the Dietary [NAME] (DC) stated that the chicken tenders were opened yesterday (03/01/25) but was not sure when they were received by the facility. DC stated that she was not sure when the fish fillets were opened or when they were last used. DC stated that she was not sure when the French fries were opened but when the staff have a question about if an item is okay to use they ask the Dietary Manager (DM) and she would let them know. The DC confirmed that it was the facility expectation for staff to write the received date and the date opened on all food items. The DC stated that if a use by date was not on the package, kitchen staff ask the DM to make sure it is okay to use. During an interview on 03/04/25 at 11:23 AM, the Dietary Manager (DM) stated that it was her expectation that all foods be labeled with the date received and the date opened.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43353 Based on interview, record review, and facility policy review, the facility failed to implement a Quality Assurance and Performance Improvement (QAPI) program when they did not adequately identify, analyze, and address issues impacting resident care through proper data collection, monitoring, and improvement initiatives related to pharmaceutical services. This had the potential to affect 85 of 85 residents who resided at the facility. The facility's failure to adequately identify, analyze, and address issues impacting resident care through proper data collection, monitoring, and improvement initiatives related to pharmaceutical services had the potential to cause serious harm to residents. Immediate Jeopardy was identified on 03/03/25 and was determined to exist on 02/26/25, in the area of S483.75 Quality Assurance and Performance Improvement at a scope and severity (S/S) of J. The Administrator was notified of the Immediate Jeopardy on 03/03/25 at 8:35 PM. The facility was notified that an acceptable plan of removal had been accepted on 03/04/25 at 7:38 PM. The survey team validated implementation of the removal plan through observations, staff interviews, and review of resident records and facility training records and the Immediate Jeopardy was removed on 03/05/25 at 1:50 PM. After removal of the Immediate Jeopardy, the deficiency remained at a D scope and severity for an isolated incident of potential harm. Findings include: Review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Plan, revised 2019, revealed, . This facility shall develop, implement, and maintain and ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems . The objectives of the QAPI Plan are to: 1. Provide a means to identify and resolve present and potential negative outcomes related to resident care and services . Provide structure and processes to correct identified quality and/or safety deficiencies. 4. Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome . Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program . The committee shall approve any corrective actions, including changes in policies and / or procedures, employment practices, standards of care, etc., and shall also monitor all corrective activities for appropriateness and/or the need the alternative measures . 1. The facility failed to monitor, protect, and prevent misappropriation of narcotic medication for one of three residents (Resident (R)8) reviewed for misappropriation out of a total sample of 21 residents. This failure had the potential to place all residents receiving narcotic pain medication at risk of serious harm of uncontrolled pain due to drug diversion. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	The facility's failure to ensure prevention of misappropriation of property related to narcotic drug diversion had the potential to cause serious harm. Immediate Jeopardy was identified on 03/03/25 and was determined to exist on 02/26/25 in the area of S483.12 Misappropriation F602 at a scope and severity (S/S) of J. The Administrator was notified of the Immediate Jeopardy on 03/03/25 at 8:35 PM. The facility was notified that an acceptable plan of removal had been accepted on 03/04/25 at 7:38 PM. The survey team validated implementation of the removal plan through observations, staff interviews, and review of resident records and facility training records and the Immediate Jeopardy was removed on 03/05/25 at 1:50 PM. After removal of the Immediate Jeopardy, the deficiency remained at a D scope and severity for an isolated incident of potential harm. Cross Reference: F602 Misappropriation 2. The facility failed to provide and maintain pharmaceutical services for the receipt, disposition, reconciliation, and control of narcotic medication for one of three residents (Resident (R)8) reviewed for medications out of a total sample of 21 residents. This failure had the potential to place all residents receiving narcotic pain medication at risk of serious harm of uncontrolled pain due to drug diversion. The facility's failure to ensure pharmaceutical services were provided to meet the needs of each resident had the potential to cause serious harm. Immediate Jeopardy was identified on 03/03/25 and was determined to exist on 02/26/25, in the area of S483.45 Pharmacy Services F755 at a scope and severity (S/S) of J. The Administrator was notified of the Immediate Jeopardy on 03/03/25 at 8:35 PM. The facility was notified that an acceptable plan of removal had been accepted on 03/04/25 at 7:38 PM. The survey team validated implementation of the removal plan through observations, staff interviews, and review of resident records and facility training records and the Immediate Jeopardy was removed on 03/05/25 at 1:50 PM. After removal of the Immediate Jeopardy, the deficiency remained at a D scope and severity for an isolated incident of potential harm. Cross Reference: Pharmacy Services 3. Review of the facility's pharmacy Omnicare Quality Improvement: Consultant Pharmacist Summary, dated 10/01/24 to 10/31/24, revealed, . Quantities on back of MAR [Medication Administration Record] do not always match quantity on Narcotic sheet (one discrepancy noted on sample audit of four residents). Please ensure staff is documenting appropriately on MAR and on narcotic sheet when controlled substances are administered for 98 charts reviewed. Review of the facility's pharmacy Omnicare Quality Improvement: Consultant Pharmacist Summary, dated 11/01/24 to 11/30/24, revealed, Quantities on back of MAR do not always match quantity on Narcotic sheet (one discrepancy noted on sample audit of four residents, please ensure staff is documenting appropriately on MAR and narcotic sheet when controlled substances are administered for 97 charts reviewed. Review of the facility's pharmacy Omnicare Quality Improvement: Consultant Pharmacist Summary, dated 01/01/25 through 01/31/25, revealed, Quantities on back of MAR do not always match quantity on Narcotic sheet (three discrepancies noted on sample audit of four residents and one discrepancy was off by three pills) for 98 charts reviewed. During an interview on 03/02/25 at 4:15 PM, the DON stated, I used to keep all the excess narcotics in my office, but we won't be anymore. They're going straight to med cart. (continued on next page)

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Ridgeway Manor Healthcare Center	117 Bellfield Road Ridgeway, SC 29130

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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	We don't have any accountability for them because no one touches them. We didn't need to have double verification for the Unit Manager (UM) to keep them in her office because she wasn't supposed to be doing it. During an interview on 03/02/25 at 5:25 PM, the Administer stated, Pharmacy will typically bring extra cards and [DON] keeps the narcotics with narcotic sheets in her office, but this process has changed now to storing them in the cart now since this incident. The DON and I have the keys. We don't do med reconciliation on them, but they're in there for storage and not accessible to anyone. During an interview on 03/03/25 at 2:50 PM, the Administer stated, We haven't addressed the pharmacy reports in QAPI yet. We do talk about them though. During an interview on 03/03/25 at 3:40 PM, the Director of Nursing (DON) stated, We go over all the pharmacy quality assurance reports. We discuss them only in QAPI, but we don't document anything on them. We haven't addressed January's pharmacy report yet. On 03/04/25 at 7:38 PM, the facility presented an acceptable plan of removal, which included: The resident's medications were replaced and the MAR show's no doses of the medication were missed. On 03/03/2025 the facility system for monitoring, identifying, reporting, tracking and investigating adverse events related to pharmacy services after noted discrepancies in narcotic medication reconciliation were reviewed and updated as necessary to ensure the safety and wellbeing of the facility residents receiving narcotic medications. On 2/26/25 education for all staff was initiated on resident abuse, neglect, and misappropriation of property. This education includes the need for immediate reporting of suspicious behavior in relation to narcotic medications and is being provided to staff from all shifts and PRN and agency staff as well and will be conducted prior their next shift. This education will be completed on or before 3/5/25. All new hires will receive this education during their orientation, prior to resident contact. Policies and procedures were reviewed by the Admin, DON, RDO, and RNC, on 3/3/25 to identify any necessary revisions to aid in control of narcotic diversion. As a result of the review updates on the narcotic count sheet process and accounting were revised on the policy tilted Controlled Substance Administration and Accountability. These changes included updating of the how the total number of meds is noted on the sheets and it now requires two nurses' signatures to add or remove medications and and for receiving medications from the pharmacy. The controlled substance card count sheet was updated to include a full count of on hand medications. With two nurse's signatures required to add or remove medications from the cart. The DON and/or Admin will audit narcotic counts and medications will be conducted three times weekly until no further instances of non-compliance are found to exist. Once compliance is achieved the audits will be conducted weekly going forward. All audit results will be provided the facility QAPI committee for review. The pharmacy report will also be reviewed monthly by the committee. The facility QAPI committee will review the narcotic count audits monthly times three months with no issues noted. Pharmacy reports will also be reviewed monthly by the QAPI Committee to ensure timely reporting is accomplished.