STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	455796	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town and Country Nursing and Rehabilitation Center	625 N Main St Boerne, TX 78006

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 2 (Resident #2 and Resident #3) of 3 residents reviewed for pharmacy services.The facility failed to ensure Resident #2 had her prescribed controlled medication, Morphine Sulfate (Concentrate) Solution 20 MG/ML available to meet her needs, disposing of controlled medication consistent with standards of practice, and documenting the administration of medications.The facility failed to ensure Resident #3 had his prescribed controlled medications, Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML and Morphine Sulfate (Concentrate) Solution 20 MG/ML available to meet his needs and documenting the administration of medications. These failures could place residents at risk of inaccurate drug administration and not having appropriate therapeutic effects.The findings included:1. Record review of Resident #2's admission Record, dated 04/23/2026, revealed a [AGE] year-old female admitted [DATE]. Resident #2 was not listed as her own responsible party with her (family member) listed as Emergency Contact #1. Record review of Resident #2's Medical Diagnoses, undated and accessed on 4/24/2026 at 8:37 p.m., revealed diagnoses including nontraumatic intracerebral hemorrhage, unspecified (is a type of stroke caused by spontaneous bleeding within the brain tissue, often associated with hypertension or other vascular risk factors, depression (common and serious mood disorder characterized by persistent feelings of sadness, loss of interest, and range of emotional physical problems), adult failure to thrive (is a syndrome in older adults characterized by weight loss, decreased appetite, poor nutrition, inactivity, and often cognitive or functional decline), altered mental status (describing any change in a person's awareness, cognition, or behavior from their baseline, ranging from mild confusion to complete unresponsiveness), and functional quadriplegia (inability to use all four extremities due to an extreme physical limitation).Record review of Resident #2's quarterly MDS, dated [DATE] and signed 03/04/2026 as completed, reflected a BIMS score of 12, indicating cognition intact. Resident #2 was documented as having health conditions, pain management and receiving scheduled pain regimen. Resident #2 was documented as having other health conditions, shortness of breath and having a condition or chronic disease that may result in a life expectancy of less than 6 months. Resident #2 was documented as receiving hospice care. Resident #2's functional abilities were documented as requiring supervision or touching assistance to partial/moderate assistance.Record review of Resident #2's care plan, undated and accessed on 04/23/2026 at 3:52 p.m., revealed Resident #2 had a terminal prognosis and was on hospice services and on pain medication therapy. The interventions included Administer medications as ordered by physician. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. [and] Work with nursing staff to provide maximum comfort for the resident. The care plan focus was created and initiated on 12/08/2025 and revised on 12/18/2025.Record review of Resident #2's Order Summary Report, dated Active Orders As of: 04/23/2026, reflected the order: Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.25 ml by mouth every 4 hours as (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
	455796	A. Building B. Wing	04/24/2026

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed for Pain Give 0.25ml to equal 5mg (20mg/ml concentrate). Order noted as Active with order date, 12/15/2025, and start date, 12/15/2025. 2. Record review of Resident #3's admission Record, dated 04/24/2026, revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE]. Resident #3 was not listed as his own responsible party with his (family member) listed as Emergency Contact #1. Record review of Resident #3's Medical Diagnoses, undated and accessed on 4/24/2026 at 8:27 p.m., revealed diagnoses including chronic obstructive pulmonary disease (COPD) (progressive lung disease that makes it difficult to breathe, primarily caused by long-term exposure to irritants like cigarette smoke and air pollution), cognitive communication deficit (condition where cognitive impairments disrupt a person's ability to communicate effectively, despite intact language and speech abilities), rheumatoid arthritis (chronic autoimmune disease that primarily affects the joints, causing pain, swelling and stiffness), adult failure to thrive (is a syndrome in older adults characterized by weight loss, decreased appetite, poor nutrition, inactivity, and often cognitive or functional decline), and muscle wasting and atrophy (loss or thinning of muscle tissue that can result from disuse, aging, or underlying medical conditions). Record review of Resident #3's quarterly MDS, dated [DATE] and signed 03/10/2026 as completed, reflected a BIMS score of 12, indicating cognition intact. Resident #3 was documented as having health conditions, pain management and receiving scheduled pain regimen. Resident #3 was documented as having other health conditions, shortness of breath and having a condition or chronic disease that may result in a life expectancy of less than 6 months. Resident #3 was documented as receiving hospice care. Resident #3's functional abilities were documented as requiring supervision or touching assistance to substantial/maximal assistance.Record review of Resident #3's care plan, undated and accessed on 04/24/2026 at 8:27 p.m., revealed Resident #3 had a terminal prognosis and was on hospice services. The interventions included Administer pain medication as ordered. [and] Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. The care plan focus was created and initiated on 03/10/2026.Record review of Resident #3's Order Summary Report, dated Active Orders As of: 04/23/2026, reflected the order: Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML (Morphine Sulfate) Give 0.25 ml sublingually every 3 hours as needed for pain/SOB Give 0.25 ml = 5 mg. Order noted as Active with order date, 12/15/2025, and start date, 12/15/2025.Record review of Resident #3's Order Summary Report, dated Active Orders As of: 04/23/2026, reflected the order:Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 10 mg by mouth every 3 hours as needed for Pain Give 0.5 ml= 10 mg. Order noted as Active with order date, 02/09/2026, and start date of 02/09/2026. During an observation and interview on 04/24/2026 at 12:52, Registered Nurse revealed Resident #2 had no narcotics stored in medication cart #1. She stated that Resident #2 had never had PRN morphine available and hospice had never provided the facility with this narcotic. Registered Nurse stated the hospice nurse would be responsible for providing the facility with Resident #2's PRN morphine medication. She stated that Resident #2 does not exhibit pain and has not complained of pain for some time and had not required morphine. She stated that typically medications are discontinued if not administered but could not recall the timeframe. Registered Nurse was observed to review Resident #2's medication that was stored and secured in medication cart #1, she reviewed the narcotic binder, and the electronic medical record to identify if there were active orders for PRN morphine. She stated there was one active order for PRN morphine for Resident #2 and there was no PRN morphine being stored in medication cart #1 for Resident #2. She noted there was no hardcopy Individual Narcotic Record for Resident #2's PRN morphine order. She stated she was not aware of this active PRN narcotic for Resident #2 prior to today. Registered Nurse stated that not having PRN pain medication available in the facility for a resident can be detrimental to their care. During an observation and interview on 04/24/2026 at 1:06 p.m., LVN A revealed that if there was an active order on the resident's chart the medication should be present and readily available for a resident. She stated that the impact of not having pain medications onsite for a resident could hurt their pain management regimen. LVN A was observed to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review Resident #3's medication that was stored and secured in medication cart #2, she reviewed the narcotic binder and reviewed the electronic medical record to identify if there were active orders for PRN morphine. She stated there were two active orders for PRN morphine for Resident #3 and there was no PRN morphine being stored in medication cart #2 for Resident #3. She noted there was no hardcopy Individual Narcotic Record for Resident #3's PRN morphine orders. She stated she recalled Resident #3's spouse did not want him to be on morphine and wanted the medication discontinued sometime in January 2026, but she was not aware of any documentation supporting this conversation.During a subsequent interview on 04/24/2026 at 1:51 p.m., LVN A noted that she was going to reach out to hospice and see if they want to discontinue the two PRN morphine orders or provide the facility with medication.During an interview on 04/24/2026 at 2:03 p.m., LVN B revealed if there are active orders for scheduled and PRN medications they should be in the facility and available. She stated that not having ordered medications on hand can be detrimental to a resident's care.During an interview on 04/24/2026 at 2:35 p.m., the Hospice RN revealed that not having ordered pain medication for a resident on hospice would not be a good thing and can harm them. She stated if there is an active order for pain medication it should be in the facility and available.During an interview on 04/24/2026 at 3:09 p.m., CMA revealed that not having scheduled or PRN medications available for a resident could cause them frustration.During an interview on 04/24/2026 at 3:23 p.m., the DON revealed that the unit nurse will communicate with the hospice nurse when medication is needed for a specific resident. She stated that when a resident complains of pain the nurse is required to check their electronic medical record for active pain orders. She stated that if narcotics were not ordered or available the resident would suffer in pain and it would be detrimental to their care. The DON stated hospice ordered and dispensed Resident #2's morphine on 12/04/2025 and if not administered in more than 60 days it would be discontinued. She stated that hospice said the morphine was dispensed on 12/04/2025 and they were under the impression the medication was still available because they could not find an order to discontinue. She stated the PRN morphine for Resident #2 was not discontinued by the provider and she could not locate the Individual Narcotic Record for Resident #2. The Director of Nursing stated that Resident #3 had one dose of morphine on 11/18/2025 0.25 ml and never administered again and then given to her for destruction on 03/02/2026. She stated the PRN morphine for Resident #3 was not discontinued by the provider and she could not locate the Individual Narcotic Record for Resident #2. During an interview on 04/24/2026 at 4:40 p.m., the Patient Care Manager revealed that there was an active PRN morphine order for Resident #2. She stated the hospice nurse and facility nurse should be communicating to ensure ordered medications are available and if not, hospice would order. She noted that if a patient discharges, passes away or no longer needs the ordered medications the hospice nurse would notify the facility nurse to destroy according to facility protocol. She stated the impact of not having active orders or comfort medication at the facility and the patient needs it for pain or morphine for shortness of breath could cause some discomfort. During an interview on 04/24/2026 at 4:55 p.m., the Clinical Team Leader revealed that there was an active order for PRN morphine 20 mg ml/oral concentrate, 3 hours as needed for Resident #3. She stated on the last visit with Resident #3 on 03/02/2026 the hospice nurse said they were not made aware the facility got rid of the PRN morphine and assumed they had it and that it was still active. She stated she was not sure what the communication issue was and it looked like a refill was needed. She stated the facility said they disposed of the medication earlier today and did not know why. She stated there was no documentation on their end of the facility communicating they were stopping the order. She stated the facility staff are required to collaborate with the hospice nurse for order changes or refills. The Clinical Team Leader stated that Resident #3 was admitted to hospice on 11/17/2025, and on 11/17/2025 PRN morphine ordered, and on 11/18/2025 PRN morphine was delivered to facility. She noted that on 1/9/2026 the hospice nurse documented facility nurse administered ordered morphine and Lorazepam SOB and shallow respirations, meant to treat shortness of breath and pain as he was diagnosed with COPD, respiratory diagnose. She noted the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	morphine and Lorazepam available at the facility just in case of an emergency as it could be problematic by not having it on hand. During an interview on 04/24/2026 at 5:20 p.m., the Director of Clinical Services revealed that the current orders written in the facility for Resident #2 include: Morphine PRN standard comfort pack, emergency e-kit to have on hand at the facility, combination of morphine, sublingual utilized as last resort for pain or SOB and is not a standard routine medication. She stated that she sees these medications as active, with no discontinuation orders. She stated the facility keeps a narcotic log, the order was filled and delivered to the facility and signed for on 12/05/2025 at 1:11 p.m., which was confirmed with their pharmacy. The Director of Clinical Services stated that the impact of not having this medication onsite depending on the severity of the symptoms and with location of facility if ordered stat, minimum of 2 hours to be delivered to the patient and the facility would have to utilize oxygen in the meantime. She stated if the medication was not available and in distress could affect them.During a subsequent interview on 04/24/2026 at 7:07 p.m., the DON stated she conducted an in-service on pain management and pain assessment and a second one on discontinuation of medications with the nurses that are currently present today. The DON stated that comfort medication packs are ordered and filled by hospice. The comfort pack includes morphine, and lorazepam. The hospice nurse will write the orders, and the facility will enter into the resident's electronic medical record. She said the information is passed on through the 24-hour report that they were placed on hospice and they have new hospice orders.During an interview on 04/24/2026 at 8:03 p.m., the Administrator stated complaint of pain protocol -the charge nurse should go and assess resident and depending what medications they have prescribed administer a pain medication. She stated if not present ideally should be notifying the physician. She stated the impact of not having pain meds available at the facility would be that pain would not be addressed and would affect residents physically and mentally.During a subsequent interview on 04/24/2026 at 9:10 p.m., the Director of Nursing revealed that she could not locate the medication administration record/destruction record nor the morphine for resident #2. She stated she believed the pharmacy made an error as it was never received. She stated she would be contacting the pharmacy for receipts of delivery.Record review of policy titled, Medication Administration, dated 10/24/2022, 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. 18. If medication is a controlled substance, sign narcotic book. 20. Correct any discrepancies and report to nurse manager. Record review of policy titled, Statement of Resident Rights, undated, revealed You have a right to: all care necessary for you to have the highest possible level of health.Record review of policy titled, Pain Management, dated 08/15/2022, revealed The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. 1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. 1. Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission.Record review of policy titled, Medication Storage and Disposal, dated 10/01/2019, revealed Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations. 3. All controlled substances remaining in the facility after a resident has been discharged , or the order is discontinued, are disposed of: A. In the facility by the Director of Nursing and/or consultant pharmacist (or others as allowed by state law) . 4. Disposition is documented on the individual controlled substance (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accountability record/book. 5. The Director of Nursing, nurse(s) and/or pharmacist witnessing the destruction ensures that the following information is entered on the individual controlled substance accountability. record/book: A. Date of destruction. B. Resident's name. C. Name and strength of medication. D. Prescription number. E. Amount of medication destroyed. F. Signatures of witnesses.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain medical records that were complete and accurately documented in accordance with accepted professional standards and practices for 2 (Resident #2 and Resident #3) of 10 residents reviewed for medical records. The facility failed to maintain a medication administration record for Resident #2's controlled medication. The facility failed to maintain a medication administration record for Resident #3's controlled medication. These failures placed residents at risk for missed treatment and medications which could result in decline in health and well-being.The findings included:1. Record review of Resident #2's admission Record, dated 04/23/2026, revealed a [AGE] year-old female admitted [DATE]. Resident #2 was not listed as her own responsible party with her (family member) listed as Emergency Contact #1. Record review of Resident #2's Medical Diagnoses, undated and accessed on 4/24/2026 at 8:37 p.m., revealed diagnoses including nontraumatic intracerebral hemorrhage, unspecified (is a type of stroke caused by spontaneous bleeding within the brain tissue, often associated with hypertension or other vascular risk factors, depression (common and serious mood disorder characterized by persistent feelings of sadness, loss of interest, and range of emotional physical problems), adult failure to thrive (is a syndrome in older adults characterized by weight loss, decreased appetite, poor nutrition, inactivity, and often cognitive or functional decline), altered mental status (describing any change in a person's awareness, cognition, or behavior from their baseline, ranging from mild confusion to complete unresponsiveness), and functional quadriplegia (inability to use all four extremities due to an extreme physical limitation).Record review of Resident #2's quarterly MDS, dated [DATE] and signed 03/04/2026 as completed, reflected a BIMS score of 12, indicating cognition intact. Resident #2 was documented as having health conditions, pain management and receiving scheduled pain regimen. Resident #2 was documented as having other health conditions, shortness of breath and having a condition or chronic disease that may result in a life expectancy of less than 6 months. Resident #2 was documented as receiving hospice care. Resident #2's functional abilities were documented as requiring supervision or touching assistance to partial/moderate assistance.Record review of Resident #2's care plan, undated and accessed on 04/23/2026 at 3:52 p.m., revealed Resident #2 had a terminal prognosis and was on hospice services and on pain medication therapy. The interventions included Administer medications as ordered by physician. Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. [and] Work with nursing staff to provide maximum comfort for the resident. The care plan focus was created and initiated on 12/08/2025 and revised on 12/18/2025.Record review of Resident #2's Order Summary Report, dated Active Orders As of: 04/23/2026, reflected the order: Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 0.25 ml by mouth every 4 hours as needed for Pain Give 0.25ml to equal 5mg (20mg/ml concentrate). Order noted as Active with order date, 12/15/2025, and start date, 12/15/2025. 2. Record review of Resident #3's admission Record, dated 04/24/2026, revealed a [AGE] year-old male admitted [DATE] and readmitted [DATE]. Resident #3 was not listed as his own responsible party with his (family member) listed as Emergency Contact #1. Record review of Resident #3's Medical Diagnoses, undated and accessed on 4/24/2026 at 8:27 p.m., revealed diagnoses including chronic obstructive pulmonary disease (COPD) (progressive lung disease that makes it difficult to breathe, primarily caused by long-term exposure to irritants like cigarette smoke and air pollution), cognitive communication deficit (condition where cognitive impairments disrupt a person's ability to communicate effectively, despite intact language and speech abilities), rheumatoid arthritis (chronic autoimmune disease that primarily affects the joints, causing pain, swelling and stiffness), adult failure to thrive (is a syndrome in older adults characterized by weight loss, decreased appetite, poor nutrition, inactivity, and often cognitive or functional decline), and muscle (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wasting and atrophy (loss or thinning of muscle tissue that can result from disuse, aging, or underlying medical conditions). Record review of Resident #3's quarterly MDS, dated [DATE] and signed 03/10/2026 as completed, reflected a BIMS score of 12, indicating cognition intact. Resident #3 was documented as having health conditions, pain management and receiving scheduled pain regimen. Resident #3 was documented as having other health conditions, shortness of breath and having a condition or chronic disease that may result in a life expectancy of less than 6 months. Resident #3 was documented as receiving hospice care. Resident #3's functional abilities were documented as requiring supervision or touching assistance to substantial/maximal assistance.Record review of Resident #3's care plan, undated and accessed on 04/24/2026 at 8:27 p.m., revealed Resident #3 had a terminal prognosis and was on hospice services. The interventions included Administer pain medication as ordered. [and] Work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. The care plan focus was created and initiated on 03/10/2026.Record review of Resident #3's Order Summary Report, dated Active Orders As of: 04/23/2026, reflected the order: Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML (Morphine Sulfate) Give 0.25 ml sublingually every 3 hours as needed for pain/SOB Give 0.25 ml = 5 mg. Order noted as Active with order date, 12/15/2025, and start date, 12/15/2025.Record review of Resident #3's Order Summary Report, dated Active Orders As of: 04/23/2026, reflected the order:Morphine Sulfate (Concentrate) Solution 20 MG/ML Give 10 mg by mouth every 3 hours as needed for Pain Give 0.5 ml= 10 mg. Order noted as Active with order date, 02/09/2026, and start date of 02/09/2026. During an observation and interview on 04/24/2026 at 12:52, Registered Nurse revealed Resident #2 had no narcotics stored in medication cart #1. RN was observed to review Resident #2's medication that was stored and secured in medication cart #1, she reviewed the narcotic binder, and the electronic medical record to identify if there were active orders for PRN morphine. She stated there was one active order for PRN morphine for Resident #2 and there was no PRN morphine being stored in medication cart #1 for Resident #2. She noted there was no hardcopy Individual Narcotic Record for Resident #2's PRN morphine order.During an observation and interview on 04/24/2026 at 1:06 p.m., LVN A revealed that if there was an active order on the resident's chart the medication should be present and readily available for a resident. LVN A was observed to review Resident #3's medication that was stored and secured in medication cart #2, she reviewed the narcotic binder and reviewed the electronic medical record to identify if there were active orders for PRN morphine. She noted there was no hardcopy Individual Narcotic Record for Resident #3's PRN morphine orders. She stated she recalled Resident #3's spouse did not want him to be on morphine and wanted the medication discontinued sometime in January 2026, but she was not aware of any documentation supporting this conversation.During an interview on 04/24/2026 at 3:23 p.m., the DON stated the PRN morphine for Resident #2 was not discontinued by the provider and she could not locate the Individual Narcotic Record for Resident #2. She said the PRN morphine for Resident #3 was not discontinued by the provider and she could not locate the Individual Narcotic Record for Resident #3. During a subsequent interview on 04/24/2026 at 9:10 p.m., the DON revealed that she could not locate the medication administration record/destruction record nor the morphine for Resident #2. She stated she believed the pharmacy made an error as it was never received. She stated she would be contacting the pharmacy for receipts of delivery.Record review of policy titled, Medication Administration, dated 10/24/2022, 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. 18. If medication is a controlled substance, sign narcotic book. 20. Correct any discrepancies and report to nurse manager. Record review of policy titled, Documentation in Medical Record, dated 10/24/2022, revealed Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. b. Documentation shall be accurate, relevant, and complete, containing (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sufficient details about the resident's care and/or responses to care.Record review of policy titled, Medication Storage and Disposal, dated 10/01/2019, revealed Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations. 3. All controlled substances remaining in the facility after a resident has been discharged , or the order is discontinued, are disposed of: A. In the facility by the Director of Nursing and/or consultant pharmacist (or others as allowed by state law) . 4. Disposition is documented on the individual controlled substance accountability record/book. 5. The Director of Nursing, nurse(s) and/or pharmacist witnessing the destruction ensures that the following information is entered on the individual controlled substance accountability. record/book: A. Date of destruction. B. Resident's name. C. Name and strength of medication. D. Prescription number. E. Amount of medication destroyed. F. Signatures of witnesses.