STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	465156	A. Building B. Wing	04/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sandstone Bountiful	523 North Main Street Bountiful, UT 84010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on observation, interview, and record review, the facility failed to ensure that the resident environment remained as free of accident hazards as was possible and each resident received adequate supervision and assistance devices to prevent accidents. Specifically, for 1 out of 26 sampled residents, a resident that was dependent on staff and required maximum assistance for bed mobility and toilet use had a brief change performed by one Certified Nursing Assistant (CNA), rolled out of the bed, and received contusions and suffered emotional distress. Resident identifier: 41. Findings included: Resident 41 was admitted to the facility on [DATE] with diagnoses which included fibromyalgia, esophageal varices without bleeding, hepatic encephalopathy, urinary tract infection, alcoholic cirrhoses of the liver with ascites, gastroesophageal reflux disease with esophagititis, essential hypertension, vitamin deficiency, mixed hyperlipidemia, hypothyroidism, gastrointestinal hemorrhage, ileus, anemia, and muscle weakness. Resident 41's medical record was reviewed on 4/24/24. On 4/24/24 at 8:15 AM, during morning medication pass an observation was made of resident 41 lying in bed. Resident 41 was tearful as she explained to Registered Nurse 1 that she had been flipped out of bed the night prior by the CNA. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 1:23 PM, a follow up observation and interview was conducted with resident 41. Resident 41 stated she preferred to have two staff members assist her when she needed to be changed but that did not always happen. Resident 41 stated she did not have use of her arms and legs and could not hold herself up or move herself in bed. Resident 41 stated the siderails were half of the size of the ones that were currently on the bed because the staff had changed them after the fall. Resident 41 stated she had minimal use of her hands and could not grab onto the side rails and they did not stop her from rolling out of the bed. Resident 41 stated when CNA 4 changed her the night prior, CNA 4 had raised the bed up all the way so that CNA 4 did not have to bend over and rolled resident 41 to her left side. Resident 41 stated she told CNA 4 she was at the very edge of the bed, was scared of falling off of the bed, and needed to be moved back to the center of the bed before they continued. Resident 41 stated before this she had asked CNA 4 to get another person to help her but CNA 4 was unable to find anyone. Resident 41 stated CNA 4 stated that she just needed to roll resident 41 a little more then grabbed the draw sheet and flipped me out of the bed. Resident 41 stated she flipped out of the bed and landed on her right side between the bed and the night stand with her body lying on the metal legs of the side table. Resident 41 stated she was crying and asked to be taken to the hospital. Resident 41 stated she was scared and did not feel safe being cared for in the facility. An observation was made of resident 41 crying throughout the entire interview. Resident 41 was observed to be able to hold a tissue and touch her phone but when resident 41 was asked if she could hold on to the bed rails, it was observed that she attempted but could not grasp the bars with her hands. A care plan Focus initiated on 4/3/24, documented [Resident 41] has an ADL [activities of daily living] self-care performance deficit r/t [related to] activity intolerance, fatigue, and limited mobility secondary to liver failure. The interventions initiated on 4/6/24, included: a. Resident was dependent on staff for bed mobility and repositioning. b. Resident was dependent on staff for personal hygiene. c. Resident was dependent on staff for toileting. d. Resident was dependent on staff for transfers. A 5 day Minimum Data Set (MDS) assessment dated [DATE], documented that resident 41 was dependent on staff for assistance, where staff does all of the effort or the assistance of two or more staff were required for the resident to complete the activity, in the areas of bed mobility, transfers, toilet use and personal hygiene. The MDS documented that resident 41 had a Brief Interview for Mental Status (BIMS) score of 15. A BIMS score of 13 to 15 would suggest that cognition was intact. On 4/5/24, a Physical Therapy note documented, Patient education bed mobility patient required MAX A (maximum assist) and cues for hand placement and use of draw sheet to roll in bed. On 4/10/24, a Physical Therapy note documented, Patient education bed mobility with cues for log roll and cues to use arms and leg to rotate, patient required MAX A. On 4/14/24 at 1:48 PM, an Advanced Skilled Evaluation noted documented, [Resident 41's] upper extremity ROM [range of motion]: Impairment on both sides. Lower extremity ROM: Impairment on both sides. Resident is bedfast all or most of the time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/19/24, a Physical Therapy note documented, Patient education bed mobility, patient required MAX A to roll in bed and cues for hand placement and to use log roll. On 4/23/24 at 9:10 PM, a Witnessed Fall Incident Report documented, Resident accidentally rolled off the bed during brief change. CNA present at the time states that 'the resident's body gave out and the lower half of her body fell off the bed and then her upper body followed behind' . resident transported to [local hospital] for evaluation. On 4/23/24 at 9:49 PM, a Nursing Note documented, Resident accidentally rolled off the bed during brief change. CNA present at the time states that 'the resident's body gave out and the lower half of her body fell off the bed and then her upper body followed behind.' Upon this nurse's arrival resident was noticed to [sic] laying on her ride side, next to her bed. Resident was hysterically crying and pleading to go to the hospital because she believed she might've 'broken something' when she landed on the leg of the side table. Resident was able to get cleaned up and transferred back into bed. No visible injuries noticed during assessment. ROM is at baseline and VS [vital signs] WNL [within normal limits BP [blood pressure]: 102/64; P [pulse]: 77; R [respirations]: 16; O2 [oxygen saturation]: 92%. Husband made aware and voiced he would also like resident be transferred to the hospital and reported he would be at the facility shortly. EMS [emergency medical services] alerted and arrived to the facility at approximately 2100 [9:00 PM]. Resident was transported to [name of local hospital redacted] for further evaluation. On 4/23/24, the hospital notes documented that resident 41 was seen for a chest contusion and shoulder bruise after the fall. Resident 41 was prescribed Oxycodone 5 milligrams every four hours for pain. On 4/25/24 at 8:59 AM, an interview was conducted with the Administrator (ADM) and the Director of Nursing (DON). The DON stated the resident fell out of bed during a brief change and their was no injury but the resident requested to be sent to the emergency room . The DON stated the bed was at the CNA's waist level when the fall occurred. The DON stated resident 41 was a one person assist and it had always been done that way. The DON stated that resident 41 was fine with a one person assist and that she had assisted resident 41 prior to this and that was what they had done. The DON stated they also discussed with physical therapy about resident 41's assistance level. The ADM then stated that everything was fine with the resident and that the resident felt like she was sliding off the bed but that she was positioned right. The DON stated that CNA 4 had stated that she felt comfortable with where the resident was placed in bed during the brief change. The DON stated that the positioning canes were in place and secure to the bed. The ADM then stated that resident 41 had limited strength in her hands but that she could grab the bar. The ADM stated that CNA 4 reported that the resident did not ask her to get additional help until she had already fallen out of the bed. On 4/25/24 at 9:14 AM, an interview was conducted with CNA 1. CNA 1 stated therapy would tell the staff what the assistance needs of a resident were after they were evaluated. CNA 1 stated resident 41 had always been a two person assist with all cares. CNA 1 stated when there were two people assisting, one person would stand one on each side of the bed to prevent the resident from falling out of the bed. CNA 1 stated resident 41 did not have much use of her hands and could not hold onto the side rails so two people needed to be in there to help support resident 41. CNA 1 stated resident 41 was usually in a lot of pain so all of her cares were done slowly. CNA 1 stated it would not be safe to perform cares on resident 41 with only one person. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 9:24 AM, an interview was conducted with CNA 2. CNA 2 stated he had worked with resident 41 a couple of times and that she needed help with being changed in bed. CNA 2 stated there would be two people to assist resident 41. CNA 2 stated the resident was weak and could not really help with the cares. CNA 2 stated when a resident was changed in bed they were repositioned so the resident was in the middle of the bed prior to being rolled to decrease the chance of them falling out of bed. On 4/25/24 at 9:29 AM, an interview was conducted with CNA 3. CNA 3 stated resident 41 was usually in a lot of pain and would sometimes help with cares but not always. CNA 3 stated resident 41 was a two person assist to roll her in bed, and one person would stand on each side of the bed to position her so she would be safe and not fall out of the bed. On 4/25/24 at 2:00 PM, a telephone interview was conducted with Licensed Practical Nurse (LPN) 1. LPN 1 stated that she was the nurse on shift when resident 41 fell out of bed. LPN 1 stated CNA 4 came and got her and said, resident 41 was on the floor and needed help getting her up. LPN 1 stated that CNA 4 had stated, she had rolled her too far and her legs were off of the bed and the top of her body followed. LPN 1 stated resident 41 was lying on her right side in between the bed and night stand and on top of the side table legs. LPN 1 stated they got her back to bed and the resident was really upset and wanted to be sent to the hospital because she felt like something cracked. LPN 1 stated that resident 41 was sent to the hospital, she did not have any injuries. LPN 1 stated she was told the resident was a one person assist but she had not assisted with her direct cares so she could not tell from personal experience. Note: multiple attempts were made to contact CNA 4 for an interview, no response received. On 4/29/24 at 9:13 AM, a follow up interview was conducted with the DON. The DON stated she expected the CNAs to review the Kardex, care plan, or talk with the nurse to determine what the resident needs were. The DON stated if the resident needs were found to be different, or if they needed more care, then she expected the staff to compensate for that. The DON stated a two person assist required one person to stand on each side of the bed when assisting with a brief change to keep the residents safe.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44640 Based on observation, interview, and record the review, the facility did not ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Specifically, for 1 out of 26 sampled residents, a resident that was observed and verbally expressed their pain was not provided pain medication in a timely manner. Resident identifier: 41. Findings included: Resident 41 was admitted to the facility on [DATE] with diagnoses which included fibromyalgia, esophageal varices without bleeding, hepatic encephalopathy, urinary tract infection, alcoholic cirrhoses of the liver with ascites, gastroesophageal reflux disease with esophagitis, essential hypertension, vitamin deficiency, mixed hyperlipidemia, hypothyroidism, gastrointestinal hemorrhage, ileus, anemia, and muscle weakness. Resident 41's medical record was reviewed on 4/24/24. On 4/24/24 at 8:15 AM, during morning medication pass an observation was made of resident 41 lying in bed. Resident 41 was tearful as she explained to Registered Nurse (RN) 1 that she had been flipped out of bed the night prior by Certified Nursing Assistant (CNA) 4 and that she had not been given pain medication since 11:00 PM, at the hospital. RN 1 stated that resident 41's narcotics were out and he would try to get her some pain medication out of the emergency kit. Resident 41 stated the emergency room prescribed her some additional pain medication and wanted to know if she could have some of that. RN 1 stated the additional medication had not come from the pharmacy yet. On 4/24/24 at 8:25 AM, RN 1 was observed to enter resident 41's room. Resident 41 was lying in bed and was teary eyed and grimacing. RN 1 stated that the emergency kit was not functioning so he was unable to get any pain medication from the house supply and could not give her any pain medication at that time. Resident 41 stated, while crying, she was hurting a lot and that she had not had pain medication for a while. RN 1 stated the pharmacy should have her pain medication to the facility between 9:00 AM and 9:15 AM, and at the latest 10:00 AM. An immediate interview was conducted with RN 1. RN 1 stated resident 41 was in pain and it was so frustrating because they were out of her pain medication because the other staff members did not reorder it when it was needed. RN 1 stated this was a common occurrence at the facility. RN 1 stated the resident should be taken care of and ultimately the lack of medication and having the machine broken only hurt the resident and caused them distress. On 4/24/24 at 9:00 AM, an observation was made of resident 41 lying in bed with her spouse at the bedside. Resident 41 was observed to tell her spouse I am in so much pain and they can't even help me. On 4/24/24 at 9:23 AM, an observation was made of resident 41 lying in bed, short moans were heard from resident 41. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/24 at 9:58 AM, an observation was made of RN 1 administering pain medication to resident 41. Note this was almost two hours after resident 41 had requested pain medication during the morning medication pass. A care plan Focus initiated on 4/3/24 and revised on 4/16/24, documented that resident 41 had acute pain/chronic pain and was at risk for acute pain related to decrease mobility, pressure ulcer and ileus. [Resident 41] has chronic pain related to neuropathy. Interventions included: Apply hot or cold packs for comfort; educate resident/representative on pain management treatment plan; educate resident/representative on prescribed analgesics and/or anti-inflammatory pain medications; encourage times of rest and relaxation between care activities; establish a pain management treatment plan; evaluate for non-verbal indicators of pain; medicate with as needed (PRN) medications if non-medication interventions are ineffective; anticipate the resident's need for pain relief and respond immediately to any complaint of pain. On 4/3/24, an Admission Pain Evaluation documented that resident 41 was able to verbalize pain, had a history of chronic pain worsened by movement and that medications and distraction helped alleviate the pain. The April 2024 Medication Administration Record and Treatment Administration Record were reviewed and documented resident 41 had the following for pain management. A physician's order dated 4/15/24, documented Oxycodone hydrochloride (HCL) Oral Tablet 5 milligrams (mg) give 5 mg by mouth every four hours for pain. And a physician's order dated 4/24/24, documented Oxycodone HCl Oral Tablet 5 mg give one tablet by mouth every four hours PRN. On 4/24/24 at 10:00 AM, an interview was conducted with RN 1. RN 1 stated he was able to get the pain medication for resident 41 and had just given it to her. RN 1 stated he had to wait for the pharmacy to bring the medication to the facility because the emergency kit was not functioning and it was frustrating for the residents and the staff. On 4/24/24 at 10:30 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the facility had one emergency kit that was used for all the residents and if it was not working then the medication would have to be brought over from the pharmacy. The DON stated they were unable to provide the narcotic pain medication for resident 41 due to her medication not being reordered and the emergency kit being broken but the nurse was able to alleviate her pain with non-pharmalogical methods. On 4/24/24 at 1:23 PM, an interview was conducted with resident 41. Resident 41 stated she was in pain most of the time, that was why the pain medication had been scheduled every four hours. Resident 41 stated the hospital had added additional pain medication to help with the pain that came with the fall out of bed. Resident 41 stated it had been a task to get the facility to make sure she had her pain medications. Resident 41 stated she had to wait a long time this morning for her pain medication and she still did not understand why it happened that way. On 4/25/24 at 9:14 AM, an interview was conducted with CNA 1. CNA 1 stated resident 41 was always in pain and when doing her cares you had to move her very slowly. CNA 1 stated sometimes resident 41 would make them wait to do cares until she had her pain medication so it did not hurt as badly. CNA 1 stated that resident 41 would tell them where they could touch her to do cares because she hurt so badly. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 9:29 AM, an interview was conducted with CNA 3. CNA 3 stated he had given resident 41 a bed bath before and it was necessary to be very gentle with her because she was always in a lot of pain. On 4/29/24 at 9:18 AM, a follow up interview was conducted with the DON. The DON stated the residents should be taken care of and their needs should be met. The DON stated to decrease the chance of running out of medications the staff were expected to reorder medications when they got low, call the pharmacy and get the medication out of the emergency kit, if needed call the physician and have them send in a prescription, and use other pain options if they have any available. The DON stated if the resident stated they were uncomfortable they could also be sent out to the hospital for pain management.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48709 Based on interview and record review, the facility failed to ensure that each resident received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Specifically, for 1 out of 26 sampled residents, behavioral health services were not provided to a resident who was assessed to need them. Resident identifier: 29. Findings included: Resident 29 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included orthopedic aftercare following surgical amputation, type 2 diabetes mellitus with diabetic neuropathy, morbid obesity, osteomyelitis, infection of amputation stump of right lower extremity, methicillin resistant staphylococcus aureus infection, acute respiratory failure with hypoxia, atrial septal defect as current complication following acute myocardial infarction, major depressive disorder, insomnia, congestive heart failure, and hypertension. On 4/23/24 at 10:05 AM, an interview was conducted with resident 29. Resident 29 stated she had been feeling depressed because of her health situation. Resident 29 stated she was on antidepressants, but she would also like to see a therapist. Resident 29 stated she spoke to an unknown staff member about two or three months ago about receiving therapy for her depression, but she had not received any behavioral health services. Resident 29's medical record was reviewed from 4/22/24 through 4/29/24. A Physician's Order dated 1/4/24, indicated, Escitalopram Oxalate Oral Tablet 20 MG [milligrams] (Escitalopram Oxalate) Give 1 tablet by mouth one time a day for depression related to MAJOR DEPRESSIVE DISORDER, RECURRENT, MODERATE. A Physician's Order dated 1/29/24 at 12:25 PM, indicated, Behavioral Health to evaluate and treat. The Preadmission Screening Resident Review (PASRR) Level II dated 1/31/24, indicated a diagnosis description of major depressive disorder, recurrent, moderate; opioid abuse, in remission; and generalized anxiety disorder. The PASRR Level II further indicated, Recommendation for Specialized Services for mental illness treatment: Referal [sic] for mental health services. A quarterly Minimum Data Set assessment dated [DATE], indicated in Section D - Mood How often do you feel lonely or isolated from those around you? Resident 29 answered, Sometimes. It further indicated in Section O - Special Treatments, Procedures, and Programs E. Psychological Therapy, Days- record the number of days this therapy was administered for at least 15 minutes a day in the last 7 days, 0. No documentation from behavioral health services was found in the medical record. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/25/24 at 9:18 AM, an interview was conducted with the Social Services Director (SSD). The SSD stated a referral was made for therapy on 2/2/24. The SSD stated an outside company came to the facility to provide behavioral health services. The SSD stated she knew resident 29 was referred but was unable to confirm that the resident had been seen by behavioral health services. On 4/25/24 at 10:58 AM, an interview was conducted with the Director of Nursing (DON). The DON stated resident 29 had a referral and that behavioral health services should have seen resident 29. The DON stated the nurse practitioner typically came in the following Monday after it was ordered. The DON stated she had not received the notes from behavioral health yet.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44640 Based on observation and interview, the facility did not label all drugs and biological's used in the facility in accordance with currently accepted professional principles, and include appropriate accessory instructions and the expiration date when applicable. Specifically, an insulin pen and a vial of Lidocaine were not labeled with an open date and were open and available for use. In addition, narcotics were repackaged into the narcotic cards. Findings included: 1. On 4/24/24 at 8:25 AM, an observation was made of the 100 hallway medication cart with Registered Nurse (RN) 1. A pre-filled pen of Lantus 100 units/milliliter was open and available for use. No open date could be seen on the pen. On 4/24/24 at 8:30 AM, an interview was conducted with RN 1. RN 1 stated the medications that were in the cart were currently being used for the residents. RN 1 stated when an insulin pen was taken out of the medication room the nurses were supposed to label it with an open date. RN 1 stated insulin was good for 30 days after it was opened but could not say how long this insulin pen was good for without a date. RN 1 was observed to place the insulin back into the medication cart for future use. 2. On 4/24/24 at 8:35 AM, an observation was made of the 100 hallway medication cart with RN 1, the following medications were located inside: a. A medication card which held Hydromorphone 2 milligrams (mg) had the back of pocket number 50 taped, no medication was located inside the pocket. b. A medication card which held Tramadol 50 mg had the back of pocket number 4 and pocket number 5 taped, no medication was located inside the pocket. c. The medication card which held Pregamblin 150 mg had the back of pocket number 57 taped, no medication was located inside the pocket. On 4/24/24 at 8:40 AM, an interview was conducted with RN 1. RN 1 stated the nurses waste a narcotic with another nurse and dispose of it in the sharps container or in a chemical solution, then both nurses sign off that the medication was wasted. RN 1 stated the nurses were not to retape any medications back into the narcotic cards. 3. On 4/24/24 at 8:55 AM, an observation was made of the 200 hallway medication cart with RN 2. A vial of Lidocaine 1 percent was observed to be open and available for use. No open or expiration date could be seen on the vial. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/24 at 9:00 AM, an interview was conducted with RN 2. RN 2 stated the medications in the cart were used for the residents and she was unsure when the Lidocaine was used. An observation was made of RN 2 discarding the Lidocaine vial. On 4/24/24 at 8:35 AM, an observation was made of the 200 hallway medication cart with RN 2, the following medications were located inside: a. A medication card which held Oxycodone 5 mg had number 46 taped, no medication was located inside the pocket. On 4/24/24 at 9:07 AM, an interview was conducted with RN 2. RN 2 stated the nurses used a chemical to discard the narcotic or placed the narcotic in the sharps container. RN 2 stated they did not tape any medications back into the medication cards. 4. On 4/24/24 at 9:30 AM, an observation was made of the 300 through 400 hallway medication cart with RN 3, the following medications were located inside: a. A medication card which held Tramadol 50 mg had number 10 taped, a white tablet was observed to have been taped back into pocket number 50. b. A medication card which held Oxycodone 5 mg had number 52 taped, no medication was located inside the pocket. c. A medication card which held Tramadol 50 mg had number 9 taped, a white tablet was observed to have been taped back into pocket number 9. d. A medication card which held Tramadol 50 mg had number 8 taped, a white tablet was observed to have been taped back into pocket number 8. e. A medication card which held Tramadol 50 mg had number 5 and pocket number 6 taped of the same card, no medications were located in the pockets. f. A medication card which held Tramadol 50 mg had number 20 and pocket number 52 of the same card were taped, no medications were located inside the pockets. On 4/24/24 at 9:50 AM, an interview was conducted with RN 3. RN 3 stated pills were not to be taped back into the medication cards. RN 3 stated there were infection control issues and the nurses could not be sure if the correct medication was retaped into the medication card. RN 3 stated the process was to waste the narcotic with another nurse. On 4/24/24 at 11:31 AM, an interview was conducted with the Director of Nursing (DON). The DON stated the nurses should waste a narcotic with another nurse. The DON stated the nurses are not to retape the narcotics into the medication cards. The DON stated when a medication was taken out of the medication storage room the date should be written on it, this included insulin and Lidocaine.