STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675326	A. Building B. Wing	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Central Texas Nursing & Rehabilitation	1800 N Broadway St Ballinger, TX 76821

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on interviews and record reviews the facility failed to ensure the resident's had the right to be informed of the risks, and participate in, his or her treatment which included the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred, for 2 of 15 residents (Resident #22 and Resident #31) reviewed for resident rights . The facility failed to obtain informed consent based on information of the benefits, risks, and options available from Resident #22 prior to administering Buspirone, an anxiolytic (antianxiety medication) used to treat anxiety. The facility failed to obtain informed consent based on information of the benefits, risks, and options available from Resident #31 prior to administering Aripiprazole, an antipsychotic medication used to treat psychosis. This failure could place residents at risk of receiving medications without their prior knowledge or consent, or that of their responsible party. The findings included: Resident #22 Review of Resident #22's Admission Record dated 4/18/24 revealed she was an [AGE] year-old female originally admitted to the facility on [DATE] with a most recent admitted [DATE]. She diagnoses which included psychotic disorder with hallucinations, dementia, and anxiety disorder. Review of Resident #22's Annual MDS assessment dated [DATE] revealed she had a BIMS (Brief Interview for Mental Status) score of 8 indicating moderate cognitive impairment, she had no reported behaviors during the look back period, she used a wheelchair for mobility in the facility and required maximum assistance for all ADLs, she was receiving an antipsychotic and an antianxiety medication, and the CAA for psychotropic drug use was triggered and checked for care planning decision. Review of Resident #22's care plan, most recent revision date 3/18/24, revealed no care plan in place for the use of antipsychotic medication or antianxiety medication. (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: 675326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER: Central Texas Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 1800 N Broadway St Ballinger, TX 76821	

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #22's Order Summary Report dated 4/18/24 revealed the following: Buspirone HCl Oral Tablet 5 MG (Buspirone HCl) - Give 2.5 mg by mouth three times a day related to unspecified dementia and anxiety disorder (Order Date: 2/15/24) Zyprexa Oral Tablet 5 MG (Olanzapine) - Give 2.5 mg by mouth one time a day for Agitation related to psychotic disorder with delusions (Order Date: 2/26/24) Review of Resident #22's chart revealed no consent for the use of buspirone. Resident #31 Review of Resident #31's Admission Record dated 4/18/24 revealed he was an [AGE] year-old male originally admitted to the facility on [DATE] with a most recent admitted [DATE]. He had diagnoses which included dementia, psychosis, major depressive disorder, Alzheimer's disease, visual hallucinations, psychotic disorder with delusions, and mood disorder. Review of Resident #31's Quarterly MDS assessment dated [DATE] revealed he had a BIMS score of 7 indicating severe cognitive impairment, he had no reported behaviors during the look back period, he required moderate to maximum assistance for all ADLs and used a wheelchair for mobility in the facility, and he was receiving an antipsychotic and antianxiety medication. Review of Resident #31's care plan last review date of 3/12/24 revealed: Focus: Resident requires antipsychotic medication for diagnosis of psychotic disorder with delusions - resident's medication aides with his history of hallucinations. Goal: The resident will be/remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction, or cognitive/behavioral impairment through review date. The resident will reduce the use of psychoactive medication through the review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Consult with pharmacy, MD to consider dosage reduction when clinically appropriate. Discuss with MD, family regarding ongoing need for use of medication. Educate the resident/family/caregivers about risks, benefits, and side effects. Monitor/document occurrence of target behavior symptoms. Monitor/record/report to MD prn side effects and adverse reactions of psychoactive medications. Focus: Resident requires antidepressant medication for diagnosis of major depressive disorder. Goal: The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. The resident will show decreased episodes of signs and symptoms of depression through the review date. Interventions: Educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms. Give antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness. Monitor/document/report to MD prn ongoing signs and symptoms of depression unaltered by antidepressant medications. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #31's Order Summary Report dated 4/18/24 revealed the following: Aripiprazole Oral Tablet 15 MG - Give 15 mg by mouth one time a day for hallucinations (Order Date: 8/11/23) Escitalopram Oxalate Oral Tablet 5 MG - Give 2 tablet by mouth one time a day related to major depressive disorder (Can change to 10 mg tabs, once daily) (Order Date: 1/26/24) Review of Resident #31's chart revealed no consent for the use of aripiprazole. In an interview on 4/18/24 at 3:02 PM with the DON, she stated that consents for psychotropic medications were her responsibility. She stated the DON was responsible for making sure they were obtained and placed in the chart and the failure was her fault. She stated that on admission, psychotropic medications were flagged in the system as needing consents and ultimately it was up to her to finalize the admission process which included the consents. She stated the psych doctors email consents to her when they are signed outside of the facility. The DON stated that any staff nurse can get a consent signed but that she should be the one ensuring that the consent was part of the medical record. Review of facility policy titled Resident Rights and Consent to Receive Psychotropic Medications revision date February 1, 2007, revealed, in part: Psychoactive medications may not be administered without the consent of residents or their legal representative, except in an emergency .Consent must be obtained before the medication may be started. If a resident is being admitted and is currently receiving a psychoactive medication, the facility will have one week (7 days) to obtain consent. The attempt to obtain this consent must be documented. The facility staff will start a tracking form for monitoring behaviors for antipsychotics and antianxiety medication and side effects for all psychotropic medications.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on observation, interview and record review the facility failed to ensure residents had the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 1 of 1 resident (Resident #2) reviewed for restraints. The facility failed to ensure Resident #2 had documented, ongoing monitoring of her lap belt use and that she used her lap belt for the least amount of time possible. This failure could place the resident at risk of unnecessarily inhibiting the resident's freedom of movement, and the possibility of skin breakdown if not released from the lap belt at regular intervals. The findings included: Review of Resident #2's Admission Record dated 4/17/24 revealed she was [AGE] year-old female originally admitted to the facility on [DATE] with a most recent admitted [DATE]. She had diagnoses which included cerebral palsy (congenital disorder of movement, muscle tone, or posture), generalized muscle weakness, muscle wasting and atrophy (decrease in size), dementia, intellectual disabilities, and convulsions. Review of Resident #2's EHR revealed a letter dated 7/10/24 which stated, It is my medical opinion that 'Resident #2' may utilize a wheelchair self-release, restraint free soft belt for patient safety to prevent sliding/falling out of wheelchair. The letter was signed by a Nurse Practitioner who provided care for Resident #2 as proof of medical necessity for the lap belt used by the resident. Review of Resident #2's Annual MDS assessment dated [DATE] revealed she was unable to complete the BIMS interview process due to sever cognitive impairment, she had short and long term memory problems, she was able to recall staff faces, she had some behaviors not directed at others reported during the look back period, she had limited range of motion in her upper and lower extremities, she used a wheelchair for mobility in the facility, she required maximum assistance or was totally dependent on staff for all ADLs, she was always incontinent of bowel and bladder, she had a PEG (percutaneous endoscopic gastrostomy) tube for nutrition, and she used a trunk restraint daily. Review of Resident #2's care plan, most recent review date 3/12/24, revealed the following: Focus: Resident #2 uses soft belt related to seizure disorder and spastic movements. She was unable to stand, so the belt does not prevent rising. She has spastic upper body movements related to cerebral palsy and was at risk for throwing herself out of the chair and injuring herself. She liked her teddy bear tucked into her soft belt. Date Initiated: 12/19/12 Goals: Resident #2 will remain free of complications related to soft belt use, including contractures, skin breakdown, mental status, isolation, or withdrawal through review date. Target Date: 6/10/24 (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: Ensure Resident #2was positioned correctly with proper body alignment while soft belt was in use. Resident needs to have soft belt applied while in chair and removed while in bed. Resident needs to have the belt released and to be checked for incontinent episodes, repositioned every 2 hours and PRN. Revision Date: 6/14/17 Review of Resident #2's Order Summary Report, dated 4/17/24, revealed the following: Soft Belt while in wheelchair; two times a day (Order Date: 4/25/2023) Observation on 4/17/24 at 1:30 PM revealed Resident #2 in her wheelchair with lap belt on. Resident #2 was sitting in lobby/dayroom with group of residents and Activity Director. Resident #2 appeared to be watching television while the other residents participated in the activity that was happening. She did not appear to be in any distress or uncomfortable during this observation. In an interview on 4/18/24 at 3:02 PM with the DON, she stated that Resident #2 was up in her chair for 3-4 hours at a time in her wheelchair using the lap belt. She stated the resident was always under direct supervision when she was in her chair wearing the lap belt. She stated that staff did release the belt more often than every 2 hours for transfers to perform care, but it was not documented as a restraint release. She stated they should be able to add restraint release to the task list for staff in the charting system. The DON stated the nursing staff perform the restraint assessments as per the facility policy, but that since the facility had the letter of medical necessity from the provider, they believed they were not required to do the same monitoring. In an interview on 4/18/24 at 4:08 PM with the Administrator, he stated that Resident #2 did spend several hours a day in her wheelchair wearing the lap belt. He stated he knew that staff stayed with her at all times while she was in her chair, and she was frequently repositioned and removed from the chair to be checked for incontinent episodes. He acknowledged the absence of documentation of restraint monitoring and release times and stated that the issue would be fixed immediately. Review of facility policy titled Restraints revision date February 1, 2017, revealed, in part: Restraint usage shall be limited to circumstances in which the resident has medical symptoms that warrant the use of restraints .Restraints will only be applied after it has been determined that a medical symptom requiring restraint usage exist, and only after other alternatives have been tried unsuccessfully. A physician's order shall be necessary to begin a restraint assessment/evaluation for the resident. The restraint committee shall meet to assess the necessity of restraints for a resident by completing a APre-Restraining Assessment worksheet. Facility staff will develop a care plan for the alternate method identified and/or the restraint usage. Restraints will only be used with informed consent from the resident and/or the resident's representative or responsible party and physician. Restrained residents must be repositioned at least every two hours and each shift. The policy did not address the need for documentation of restraint release or repositioning of the resident in restraints

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45411 Based on interview and record review the facility failed to develop and implement a comprehensive, person-centered care plan for each resident that included measurable objectives and time frames to meet, attain, and/or maintain the resident's highest practicable physical, mental, and psychosocial well-being for 2 of 15 residents (Residents #22 and Resident #56) reviewed for care plans. The facility failed to ensure that Resident #22 had a care plan in place for the use of psychotropic medications. The facility failed to ensure that Resident #56 had a care plan in place for his orthotic flexion gloves (therapy gloves used to help the resident curl his fingers into a fist) or his PEG tube (percutaneous endoscopic gastrostomy - tube inserted into the stomach used for nutrition due to swallowing difficulties). These failures could affect residents by placing them at risk of not receiving individualized care and services to meet their needs. The findings included: Resident #22 Review of Resident #22's Admission Record dated 4/18/24 revealed she was an [AGE] year-old female originally admitted to the facility on [DATE] with a most recent admitted [DATE]. She diagnoses which included psychotic disorder with hallucinations, dementia, and anxiety disorder. Review of Resident #22's Annual MDS assessment dated [DATE] revealed she had a BIMS (Brief Interview for Mental Status) score of 8 indicating moderate cognitive impairment, she had no reported behaviors during the look back period, she used a wheelchair for mobility in the facility and required maximum assistance for all ADLs, she was receiving an antipsychotic and an antianxiety medication, and the CAA for psychotropic drug use was triggered and checked for care planning decision. Review of Resident #22's care plan, most recent revision date 3/18/24, revealed no care plan in place for the use of antipsychotic medication or antianxiety medication. Review of Resident #22's Order Summary Report dated 4/18/24 revealed the following: Buspirone HCl Oral Tablet 5 MG (Buspirone HCl) - Give 2.5 mg by mouth three times a day related to unspecified dementia and anxiety disorder (Order Date: 2/15/24) Resident #56 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #56's Admission Record dated 4/17/24 revealed he was a [AGE] year-old male originally admitted to the facility on [DATE] with a most recent admitted [DATE]. He had diagnoses which included injury at C1 level of cervical spinal cord, stroke, cervical spondylosis with myelopathy (neurologic degenerative changes of the spine at the neck resulting in compression of the spinal cord and nearby structures), and dysphagia (difficulty swallowing. Review of Resident #56's Annual MDS assessment dated [DATE] revealed he had a BIMS score of 3 indicating severe cognitive impairment, he had no reported behaviors, he required maximum to total assistance for all ADLs and used a wheelchair for mobility in the facility, he received enteral feeding via PEG tube, and the CAA for feeding tube was triggered and checked for care planning decision. Review of Resident #56's Order Summary Report dated 4/17/24 revealed the following: Gloves to be worn as tolerated for hand training/movement (making a fist) per therapy q shift - two times a day for hand movement (Order Date: 2/21/24) Enteral Feed - every shift Head of bed up at least 30 degrees during administration of enteral formula or water (Order Date: 7/14/23) Enteral Feed - two times a day for Hold Feeding if residual is over 100ml Check residual before medications and feedings; return contents after each check (Order Date: 7/14/23) Enteral Feed - one time a day Cleanse g-tube site (Order Date: 7/14/23) Enteral Feed - every shift Check placement prior to feeding and medication administration (Order Date: 7/14/23) Enteral Feed - every night shift Change syringe Q 24 hours (Order Date: 7/14/23) Enteral Feed - as needed Change tubing with each enteral feeding set-up (Order Date: 7/15/23) Enteral Feed - every shift Flush with at least 5mls of water between each medication (Order Date: 7/14/23) Enteral Feed - five times a day for via peg tube Isosource 1.5; Tube feeding Bolus: 237ml; Flush Water 30ml before and after feeding (Order Date: 7/18/23, Revision Date: 8/31/23) Enteral Feed - every shift Flush with 50 cc of water before and after feedings (Order Date: 7/25/23) Enteral Feed - every shift Flush with 250 cc of water twice a day (Order Date: 7/25/23) Review of Resident #56's care plan, most recent review date 4/16/24, revealed no care plan in place for his PEG tube or his orthotic flexion gloves. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/18/24 at 10:10 AM with the DOR (Director of Rehab), she stated she did not put anything in the care plan. She stated she attended the care plan meetings and nursing staff, either the DON, ADON or MDS nurse, documented while they were meeting about what needed to be on each resident's care plan regarding the therapy department. The DOR stated without a care plan for the gloves, she stated there was no way the nursing staff would know, and she would have to in-service them. In an interview on 4/18/24 at 2:30 PM with the MDS nurse, she stated that a care plan should be person centered - it should outline what level of care needs to be provided regarding ADLs, the resident's likes and dislikes, potential behaviors and how to resolve them, diet, all medications and why the resident was taking the medication, any special treatments like physical therapy/occupational therapy/speech therapy/dialysis, any skin concerns or wound care so that all staff would know about potential or existing issues. She stated that the entire IDT team was able to contribute to what was added to the care plan, including the family. Regarding whom was able to access and put items into the care plan in the computer, she stated that she (MDS nurse), the social worker, the DON, the ADON, the Dietary Manager, the Activity Director, and the DOR all had the ability to add information to the care plan. She stated she thought the floor nurses could add information, but she was not certain how much access they had. The MDS nurse stated she did not know why Resident #22's care plan did not include her psychotropic medication use and that it was just an oversight and would be corrected immediately. She stated that she thought that Resident #56 had a care plan for his orthotic gloves and when she opened his care plan it showed that after being interviewed by this surveyor, the DOR put a care plan in detailing the glove use. The MDS nurse also stated that she thought that because Resident #56 had a care plan in place for his NPO status that mentioned his PEG tube that was sufficient. In an interview on 4/18/24 at 3:02 PM with the DON, she stated that a care plan should reflect everything a person would need to know to take care of a resident in the sense of all the medical diagnoses and related medications, ADLs, diet, activity preferences, and behaviors. She stated that she (the DON), the ADON, the MDS nurse, the social worker, the Dietary Manager, the Activity Director, and the DOR could enter care plans into the chart. She stated she did do care plan audits as needed, but she did not have a formal process for the audits. The DON stated that Resident #22's psychotropic medications should have been care planned as well as Resident #56's PEG tube and orthotic gloves. Review of undated facility policy titled Comprehensive Care Planning revealed, in part: Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. When developing the comprehensive care plan, facility staff will, at a minimum, use the Minimum Data Set (MDS) to assess the resident's clinical condition, cognitive and functional status, and use of services.

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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. 30057 Based on observation, interview and record review the facility failed to provide pharmaceutical services, including procedures that ensure the accurate administering of all drugs to meet the needs of the residents, for 1 (medication cart in secure unit) of 3 medication carts reviewed for pharmacy services, in that: The medication cart used for the secure unit had an insulin pen that had expired as indicated by the manufacturers recommendations. This failure could place residents at risk of receiving medications that were expired and not produce the desired effect. The findings were: During an observation and interview on 04/16/24 at 11:44 AM the medication cart in the secure unit was inspected with LVN A present. In the top drawer of the medication cart was one insulin pen that was dated 03/06/24. LVN A said the insulin pen was good for 28 days once they were opened. LVN A said she believed it was the night shift staff that were supposed to monitor the medication cart and inspect for expired or undated medications. LVN A said if a resident received an expired insulin, it might not be as effective or produce the desired effect. LVN A said she would dispose of the expired insulin and had not noticed that the insulin had expired. During an interview on 04/18/24 at 10:30 AM the DON said it was her expectation for staff to label and date the insulin pens with the expiration dates when first opened and dispose of the expired ones. The DON said she encouraged nurses to monitor the medication carts and disposed of expired medications. The DON said the ADON was delegated to check the medication carts to see if there were any expired medications and also that they were labeled and dated. The DON said if a resident received an expired medication it could lead to an adverse reaction or not receive the desired effect. During an interview on 04/18/24 at 10:52 AM the Administrator said his expectation was for staff to date medications when opened and discard them when expired. The Administrator said the ADON was delegated to check the carts for expired medications and also their pharmacist would conduct medication checks when they came by the facility. The Administrator said if a resident received expired medication, it could not be as effective. During an interview on 04/18/24 at 10:58 AM the ADON said he would check the medication carts every two weeks. He said he would check for expired medications and that he must have missed that one insulin that was expired. He said if a resident received an expired medication, they might not receive the desired effect. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's policy dated 2003 and titled Medications that must be dated when opened or storage conditions changed indicated in part: All the medications below should have the date opened written on the medication and/or container it arrived in. Insulins (Vials, cartridge, Pens) Keep refrigerated until needed for use. Expiration is based on manufactures recommendations after opening and/or stored at room temperature. Record review of the facility's in-service dated 04/16/24 and titled Medication expiration dates indicated in part: When insulin or new meds are opened nursing must document an expiration date of 28 days from open date. Any medications that are expired must be removed from the med cart and discarded per policy.

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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 - Few	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. 48593 Based on observation, interview, and record review, the facility failed to ensure all controlled drugs and biologicals were stored in separately locked and permanently affixed compartments for the facilities only medication room reviewed for labeling/storage of drugs and biologicals. The facility failed to provide separately locked, permanently affixed compartments for the storage of controlled drugs. These failures could place the facility at risk of drug diversion and access to medications. Findings included: Observation of the facility medication room with LVN B on 04/16/2024 at 03:32 pm revealed a narcotic lock box in the locked medication refrigerator. The Narcotic lock box was not secured to the fridge. The box contained four boxes of lorazepam 2mg/ml. An interview with LVN B on 04/16/2024 at 03:34 pm, stated the lock box was normally glued to the bottom of the fridge but it had gotten dislodged at some point. LVN B was unsure how long the box had been loose in the fridge. LVN B states she was off for a week and when she last worked the box was affixed to the fridge. An interview with the DON and Administrator on 04/16/24 at 10:32 am the DON stated that the narcotic box should be permanently affixed and locked to prevent controlled drug diversion. The DON had no reason the lock box would not be properly locked or affixed. The DON was unaware the box was not affixed. The administrator stated he was informed by maintenance they are trying to obtain a chain for the lock box but needs approval from the pharmacy company to be able to alter the lock box. Unable to provide any documentation of conversation. A review of the facility policy titled Storage and Documentation of Schedule II Controlled Medications, provided by the DON, reads, in part, All Schedule II controlled medications will be stored under double lock and checked for accountability at each change of shift . With a date of 2003.