STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675887	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Joseph Manor	2333 Manor Dr Bryan, TX 77802

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interviews, and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practices that are complete and accurately documented for 3 of 14 residents (Resident #1, Resident #2, and Resident #3) reviewed for medication administration, treatment administration, and wound administration. 1. The facility failed to complete Resident #1's Medication Administration Record (MAR), Treatment Administration Record (TAR), Wound Administration Record (WAR), and Controlled Drug Record for Norco 5-325 MG, Norco 10-325 MG, Pregabalin, tramadol PRN, tramadol three times a day and wound cleanse treatments. 2. The facility failed to accurately document Resident #1's Medication Administration Record (MAR), Treatment Administration Record (TAR), Wound Administration Record (WAR), and Controlled Drug Record for Norco 5-325 MG, Norco 10-325 MG, Pregabalin, tramadol PRN, tramadol three times a day and wound cleanse treatments. 3. The facility failed to accurately document Resident #1's Controlled Drug Record for Hydrocodone-Acetaminophen 5-325 MG on 01/20/2025 at 5:00 PM with 58 tablets remaining and next entry on 01/21/2025 at 12:01 AM reflecting 56 tablets remaining, 4. The facility failed to complete Resident #2's Medication Administration Record (MAR) for Lorazepam 0.5 MG for 12/1/2024 thru 12/31/2024 and 1/1/2025 thru 1/31/2025. 5. The facility failed to complete Resident #2's Medication Administration Record (MAR) for Lorazepam 0.5 MG to reflected wrong dose of 2 tablets administered on 4/21/2024 as reflected on Resident #2's Controlled Drug Record for Hydrocodone. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. The facility failed to accurately document Resident #3's Medication Administration Record (MAR) for Hydrocodone for 04/21/2025 of three doses administered for the day as reflected on Resident #3's Controlled Drug Record for Hydrocodone. 7. The facility failed to follow facility procedures to document a medication error in Resident #1, Resident #2, and Resident #3's electronic medical record, notify the physician, and notify the Resident's Representative. This deficient practice placed residents who receive medications, treatments, and wound care from facility staff at risk for less than therapeutic benefits, and/or not receiving ordered medications, treatment, or wound care due to inaccurate documentation of administration. Findings included: Review of Resident #1's face sheet reflected a [AGE] year old woman with an initial admission date of 1/17/2025 with diagnoses of cellulitis of abdominal wall, end stage renal disease (a medical condition where the kidneys have permanently lost their ability to function adequately), dependence on renal dialysis, morbid obesity due to excess calories (a medical condition where Body Mass Index (BMI) of 40 or higher), essential (primary) hypertension (a medical condition where a person's abnormally high blood pressure that's not the result of a medical condition), and anemia in chronic kidney disease (a medical condition where a person's blood has a lower-than-normal amount of red blood cells or hemoglobin). Review of Resident #1's MDS dated [DATE] reflected a BIMS of 11 and had an active pain management regimen for frequent pain, documented surgical wounds and open lesion(s) other than ulcers, rashes, cuts, and taking antidepressants. Review of Resident #1 active orders as of 01/21/2025 reflected resident had order for abdomen wound cleanse for wound healing three times a week with an order date of 01/21/2025. Further review reflected an order for Review of 48-hour baseline care plan dated 01/17/2025 reflected resident had pain goal to experience less pain with medications, Norco, Tramadol, Acetaminophen and Pregabalin. Further review reflected resident had a pressure sore/skin at risk goal: prevent/heal pressure sores, resolve skin condition with treatment of Vacuum-Assisted Wound Closure (VAC) (a method of decreasing air pressure around a wound to assist the healing). Additional care plan summary reflected, We will monitor for signs of infection, manage pain, maintain hygiene around the wound .emphasizing the importance of maintaining a clean, airtight seal around the wound to ensure optimal healing with the vacuum therapy .as well as understanding the importance of regular monitoring and not missing treatment days. Review of Resident #1 active orders as of 01/17/2025 reflected resident had order for Norco 5-325 MG (narcotic) every 4 hours as need for moderate to severe pain (6-10) for cellulitis of abdominal wall with a start date of 01/17/2025. Further review reflected active orders as of 01/21/2025 for Norco 10-325 MG (narcotic) every 4 hours as needed for pain with a start date of 01/21/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1 active orders as of 01/17/2025 reflected resident had order for Pregabalin (narcotic) two time a day for end stage renal disease with a start date of 01/18/2025. Review of Resident #1 active orders as of 01/18/2025 reflected resident had order for tramadol (narcotic) every 8 hours as needed for pain (PRN) with a start date of 01/18/2025. Further review reflected active orders of 01/22/2025 for tramadol (narcotic) three times a day for cellulitis of abdominal wall with a start date of 01/22/2025. Review of Resident #1 active orders as of 01/18/2025 reflected resident had order for abdomen cleanse wound/wound cleanser Peri wound VAC drape [NAME] 125 one time a day three times a week for wound healing with a start date of 01/20/2025. Further review reflected active orders as of 01/21/2025 reflected resident had order for abdomen cleanse wound/wound cleanser Peri wound VAC drape [NAME] 150 one time a day three times a week for wound healing with a start date of 01/22/2025. Review of Resident #1 active order as of 01/22/2025 reflected resident had order for left groin cleanse wound with NS/wound cleanser Primary Dressing: Calcium Alginate, Santyl Secondary Dressing: ABD pad Secure with: tape as needed one time a day for wound healing with a start date of 01/22/2025. Review of Resident #1 Medication Administration Record (MAR) reflected tramadol every 8 hours PRN had no administration entries. Review of Resident #1 Medication Administration Record (MAR) reflected tramadol three times a day was administered once on 01/22/2025, three times on 01/23/2025 to 01/30/2025, and once on 01/31/2025. Review of Resident #1 Medication Administration Record (MAR), Treatment Administration Record (TAR) and Wound Administration Record reflected abdomen cleanse wound/wound cleanser Peri wound VAC drape [NAME] 125 for January 2025 reflected no order data found. Further review reflected Medication Administration Record (MAR), Treatment Administration Record (TAR) and Wound Administration Record reflected abdomen cleanse wound/wound cleanser Peri wound VAC drape [NAME] 150 for January 2025 reflected no order data found. Review of Resident #1 Medication Administration Record (MAR), Treatment Administration Record (TAR) and Wound Administration Record reflected left groin cleanse wound with NS/wound cleanser Primary Dressing: Calcium Alginate, Santyl Secondary Dressing: ABD pad Secure with: tape for January 2025 reflected no order data found. Review of Resident #1 Medication Administration Record (MAR) reflected Norco 5-325 MG (Hydrocodone-Acetaminophen) was administered on 01/20/2025 at 9:03 AM with pain level of 3 and 01/20/2025 at 5:50 PM with pain level of 3. Further review of Resident #1 Medication Administration Record (MAR) reflected Norco 10-325 MG (Hydrocodone-Acetaminophen) was administered on 01/21/2025 at 12:48 PM, 01/21/2025 at 11:37 PM, 01/22/2025 at 7:54 AM, 01/22/2025 at 1:56 PM, 01/23/2025 at 2:09 PM, 01/25/2025 at 6:33 AM, 01/26/2025 at 9:10 AM, and 01/28/2025 at 6:54 AM. Review of Resident #1 Medication Administration Record (MAR) reflected Pregabalin was administered on twice on 01/19/2025, twice on 01/20/2025, twice on 01/21/2025, twice on 01/22/2025, twice on 01/23/2025, twice on 01/24/2025, twice on 01/25/2025, twice on 01/26/2025, twice on 01/27/2025, twice on 01/28/2025, twice on 01/29/2025, twice on 01/30/2025, twice on 01/31/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1 Controlled Drug Record reflected tramadol every 8 hours (three times) was administered once on 01/21/2025, once on 01/22/2025, three times on 01/23/2025 to 01/24/2025, twice on 01/25/2025, once on 01/26/2025, and once on 01/27/2025 with 18 tablets remaining. Review of Resident #1 Controlled Drug Record reflected Pregabalin was administered on twice on 01/19/2025, twice on 01/20/2025, twice on 01/21/2025, twice on 01/22/2025, twice on 01/23/2025, twice on 01/24/2025, twice on 01/27/2025, and once on 01/28/2025 with a remaining capsule amount of 45. Review of Resident #1 Controlled Drug Record reflected Hydrocodone-Acetaminophen 5-325 MG was administered on 01/20/2025 at 9:00 AM with 59 tablets remaining, 01/20/2025 at 5:00 PM with 58 tablets remaining, 01/21/2025 at 12:01 AM with 56 tablets remaining, 01/21/2025 at 7:00 AM with 55 tablets remaining, 01/21/2025 at 6:00 PM with 54 tablets remaining, 01/21/2025 at 11:48 PM with 53 tablets remaining, 01/22/2025 at 6:00 AM with 52 tablets remaining, 01/22/2025 at 8:00 AM with 50 tablets remaining, and 1/22/2025 at 12:00 PM with 48 tablets remaining. Review of Resident #1 Controlled Drug Record reflected Hydrocodone-Acetaminophen 10-325 MG was administered on 01/23/2025 at 2:00 PM with 29 tablets remaining, 01/25/2025 at 6:00 AM with 28 tablets remaining, 01/26/2025 at 10:00 AM with 27 tablets remaining, and 01/28/2025 at 6:55 AM with 26 tablets remaining. Review of Resident #2's face sheet reflected a [AGE] year-old male with an admission date of 03/12/2025 and initial admission date of 07/27/2022 with diagnoses of schizoaffective disorder, bipolar type, unspecified dementia, severe, with psychotic disturbance. Review of Resident #2's MDS dated [DATE] reflected a BIMS of 04 and an active diagnosis of schizophrenia, depression, and bipolar disorder. Review of Resident #2 active orders as of 05/30/2024 reflected resident had order for Lorazepam 0.5 MG (narcotic) every 4 hours as needed for anxiety with start date of 05/30/2024. Review of Resident #2 Medication Administration Record (MAR) for 12/1/2024 thru 12/31/2024 and 1/1/2025 thru 1/31/2025 reflected Lorazepam 0.5 MG had no order data found. Review of Resident #2 Controlled Drug Record reflected Lorazepam 0.5 MG was administered three times on 10/16/2024 with 2 tablets administered at 11:30 PM, once on 10/23/2024, once on 10/25/2024, once on 11/12/2024, once on 12/19/2024, and once on 1/21/2025 with 27 tablets remaining. Review of Resident #3's face sheet reflected a [AGE] year-old female with an admission date of 01/10/2023 with diagnoses of unspecified dementia (is not specified by a doctor), low back pain, and pain unspecified. Review of Resident #3's MDS dated [DATE] reflected a BIMS of 08 and an active diagnosis of unspecified dementia and low back pain, unspecified. Review of Resident #3 active orders as of 11/12/2024 reflected resident had order for Hydrocodone 5-325 MG two times a day for pain management with a start date of 11/12/2024. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #3 Medication Administration Record (MAR) for 04/1/2025 - 04/30/2025 reflected Hydrocodone was administered twice a day from 04/01/2025 thru 04/30/2025. Review of Resident #3 Controlled Drug Record reflected Hydrocodone was administered three times on 4/21/2025 with two does at 7:00 PM. In an interview on 6/6/2025 at 9:58 AM LPN C stated the procedures of administering medication includes prescribed by physician, right patient, right medication, right dose. She stated if the wrong medication was administered immediately notify doctor of what was administered vs. what should have been administered, report to DON, a medication error report should be filled out, this was a paper form as it requires signatures, but the facility was currently transitioning out of this process. The least there should an incident report on the medication error. LPN C stated she feels there is room for improvement, current process needs to change. She stated she doesn't want to get anyone in trouble, but the current Medication Administration Record (MAR) and narcotic record logs are not being done correctly and this needs to be corrected. This practice could have a serious effect on a resident and their care. In an interview on 6/6/2025 at 10:28 AM MA stated the procedures if a medication error occurred is to notify the charge nurse, the nurse notifies the DON, notify the physician, watch the resident for the next 24 hours, do vitals every 3-4 hours and submit an error report to the DON. The DON would then follow-up with staff who made the medication error and provide individual counseling. She stated not notifying the charge nurse of medication errors can have serious consequences for residents and can have serious harm on them. In an interview on 6/6/2025 at 11:12 AM LPN B stated if she were to identify a medication error, she would notify the DON and physician, investigate why dose was missed or not given, determine if the resident refused and review resident's record to see if information was documented in progress notes. She stated all medication errors could be harmful to the resident and should always be documented and DON should always be notified. In an interview on 6/6/2025 at 1:24 PM DON stated she provides staff with medication administration in-services. She stated she has not had any medication errors reported or documented by staff. She stated medication administration procedures includes the 6 rights - right does, right resident, right time. She stated she has trained staff to make sure delayed medication is not given to resident as this would be a wrong dose. A medication error as such would require staff to contact the nurse practitioner and stated staff have not reported medication errors to her. She stated not following these procedures can pose a safety issue for residents. She stated the narcotics require a Medication Administration Record (MAR) and a count sheet, which helps staff to keep medications counted for, correct times, documenting should be on count sheet and PCC. Reasons for Medication Administration Record (MAR) and count sheet is to ensure safety for residents. She stated that the pharmacist reviews resident's narcotic records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 6/6/2025 at 2:54 PM DON stated she was unaware prior, but the narcotics that are PRN are separated from the narcotics that are scheduled. DON stated there are two different carts that carry narcotics and scheduled medications separately. She added that there are also different narcotic record count logs for scheduled and for PRN narcotics. She was observed searching through the carts and searching for the narcotic blister packs and narcotic logs for Resident #3. DON was able to locate the narcotic blister packs for both the PRN and scheduled narcotics for Resident #3; however, she was unable to locate the narcotic record logs for discontinued medications and discharged residents are kept. In an interview on 6/6/2025 at 3:21 PM ADON stated medication administration timeframe window is one hour before and one hour after, staff is to document Medication Administration Record (MAR) after it is administered. Depending on the medication and orders staff may need to get blood pressure and pulse before administering. ADON stated narcotics documentation of pain scale may be required before and after administering, checking resident vital signs and will not give narcotics if blood pressure and/or pulse is low as respiratory system can be compromised with narcotics. She stated PRN narcotics require follow up. She stated if staff have a medication error they are required to report it to the DON. She stated staff would be required to self-report, make progress notes of medication error on the Medication Administration Record (MAR) and notify physician for directions. She stated she is not aware of any medication errors since her employment with the facility, beginning April 2025. she has been employed at this facility. In an interview on 6/6/2025 at 3:37 PM MEDRC stated facility medical records retention policy was 7 years. She stated that she was tasked with locating the records of discharged residents and of discontinued narcotic records and she was unable to locate them. She stated she was not sure what the direct care staff did with these records, and she relies on the DON to submit them to her. In an interview on 6/6/2025 at 3:41 PM DON stated she believes the missing narcotic logs are a process issue and the medications were administered as prescribed. She stated she was not aware that she should turn in discharge records or discontinued medication logs to the records staff. In a phone interview on 6/6/2025 at 4:35 PM Clinical [NAME] President (CL VP) stated she was working on mapping the current issue onsite regarding medical records. She stated staff are working on producing missing logs. She stated she understands the facility needs to put a new system in place for the facility to ensure this doesn't occur in the future. She stated the current process regarding the retention of narcotic medication count needs to be corrected. She stated the DON should be responsible for the discontinued and discharge narcotic records She also stated staff will be ensuring only one narcotic record log is used for all residents being administered narcotics moving forward. She stated she would be working with the team to include ADM and DON in making these necessary changes to ensure resident safety. In an interview on 6/11/2025 at 4:14 PM LPN WC stated the nursing staff have been in-serviced to document all medication administration, treatment administration, and wound care administration in the resident's Medication Administration Record (MAR), Treatment Administration Record (TAR), and Wound Administration Record (WAR). If there is any deviation of the administration to notify the charge nurse to take the necessary steps to correct the issue. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/12/2025 at 11:55 AM LPN WC B was asked by the DON to help verify wound care documentation that could not be located for Resident #1. LPN WC B stated she was responsible for wound care treatment and left employment at the facility at the end of February 2025. She stated she had documented Resident #1's Treatment Administration Record (TAR), and Wound Administration Record (WAR) with treatments she was given orders for. She stated she also entered progress notes surrounding any wound care treatment provided. LPN WC B stated she worked with the DON to locate these records and she was unsuccessful. She stated there was a lot of tension and friction working here at the facility because her treatment notes would be removed from the medical record. She stated she reported these issues directly to the ADM and DON and believes the Clinical [NAME] President (CL VP) was responsible for editing medical records and removing progress notes, deleting Medication Administration Record (MAR), Treatment Administration Record (TAR), and Wound Administration Record (WAR). She believes this was being done only to her entries. She stated she ultimately decided to leave this facility because of these challenges. Interview on 6/12/2025 at 12:51 PM DON stated she was familiar with Resident #1's care while she was a resident at the facility. She stated the Resident #1 was receiving wound care treatment and narcotics related to wound care. She stated she has reviewed the full chart for Resident #1, and she has not been able to locate the Medication Administration Record (MAR), Treatment Administration Record (TAR), and Wound Administration Record (WAR) for the month of January 2025 when she was a resident. She stated she cannot locate any treatment notes provided by LPN WC B. She stated the orders are present and accounted for, but not listed on the Treatment Administration Record (TAR), DON stated that LPN WC B reported wound care treatment to WC PH, but there is no supporting documentation of this progress. DON stated that she believes the wound care treatment was performed and documented, but for some reason the documentation is not accessible. Interview on 6/12/2025 at 12:51 PM ADON stated she has been searching through Resident #1's medical records and she is unable to locate the Medication Administration Record (MAR), Treatment Administration Record (TAR), and Wound Administration Record (WAR) for wound care treatment, and she was not able to locate the narcotic record either. She stated the wound care was provided for Resident #1, but the administration records are not present. Interview on 6/12/2025 at 1:41 PM RG RN stated she reviewed Resident #1, Resident #2, and Resident #3'sprogress notes, Medication Administration Record (MAR), Treatment Administration Record (TAR), and Wound Administration Record (WAR) and she is unable to determine why there is documentation missing or not saved in the medical record. She stated there are physician notes to verify treatment and medication orders are present; however, there is no documentation to support the treatment or medication was administered. She stated the missing, incomplete, inaccurate, and unorganized documentation can be a serious problem for the care provided to residents and this is an area that needs to be worked on. She stated staff are being in-serviced on the importance of documenting the administration of medications, treatments, and wound care. In an interview on 6/12/2025 at 2:33 PM LPN A stated if he is performing wound care on a new admission the procedure is to follow standing orders if no orders come with the resident. Standing orders include cleaning the wound, putting dressing, putting in orders for treatment, documenting progress notes the treatment provided, entering information on medication, treatment, and wound administration records. He stated the administration records are important to the care of the resident and need to be entered. All staff receive training on the importance of these records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 6/12/2025 at 3:20 PM DON stated she was aware of previous issues with skin concerns and felt it necessary to conduct a full skin sweep of all residents at the facility. This skin sweep was conducted on 6/10/2025. She stated she does believe the wound care treatment was provided to Resident #1 and the ordered medications were administered correctly to Resident #1, Resident #2, and Resident #3 despite the unsporting documentation. DON stated the main issue here is the documentation. She stated staff will get better with documenting their progress, the treatments and medications provided to the residents. She stated the staff have received medication administration in-services within the last 30 days and will continue to in-service on the importance of complete, accurate, and organized documentation. In a phone interview on 6/12/2025 at 4:24 PM PCP stated he has been in contact with the ADM and DON regarding Resident #1's missing documentation. He stated the team reached out to him and they were able to complete a QAPI meeting. He stated the team emphasized the wound care was done for the resident and the concern is the wound care wasn't documented as detailed as it should have been. He she the facility now has a wound care nurse that is different and documenting more and staying on top of it. He stated the wound care was getting done, not getting worse, treatment was being done using the standing order process. He understands documenting care was little to none. In his opinion if after seeing the wound if he believed the wound was not getting better or declining, he would have extended the course of antibiotics Resident #1 was on. PCP stated his NP tends to use a standard template, which he has counseled her against. He stated at times the standard template will not fully capture the full visit with the resident. He will remind his NP to not use a template for progress notes as this can get her and the facility into issues. He asked for additional time to review additional medical file to give opinion on. In a phone interview on 6/12/2025 at 5:22 PM PCP stated he is a firm believer that just because you provided the care of treatment without it being documented it is as if you didn't perform it. He stated he will stress to the facility and the administration staff the importance of documenting all administration for a resident, they will be in-servicing on this topic, also to include standing orders, what steps to take when a new wound is noticed, automatically documenting the chart. He stated a lot of in-servicing is needed and the staff needs to be better with documenting in PCC. He stated the documentation and records retention for narcotic records needs to be a priority and will also be in-serviced and part of the quality assurance and performance improvement (QAPI). He stated that he did speak to the team to include the corporate nurse regarding complete, accurate, and organized documentation in PCC. Record review of Medication Administration Policy, reference date 2024 revealed, 10. Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Right dosage d. Right route e. Right time f. Right documentation 11. Review Medication Administration Record (MAR) to identify medication to be administered. 12. Compare medication source (bubble pack, vial, etc.) with Medication Administration Record (MAR) to verify resident name, medication name, form, dose, route, and time. 20. Sign Medication Administration Record (MAR) after administered. For those medications requiring vital signs, record vital signs on the Medication Administration Record (MAR). 21. If medication is a controlled substance, sign narcotic book. 23. Correct any discrepancies and report to nurse manager. Record review of Wound Treatment Management Policy, reference date 2019, revealed 7. Treatments will be documented on the Treatment Administration Record or in the electronic health record. Record review of documented titled, Controlled Drug Receipt/Proof-Of-Use/Disposition form, no date provided, revealed the form provided a reminder to the staff administering medication, Each dose signed for here requires charting on the medication record. Record review of the facility's (3) narcotic record logs in use, Controlled Drug Receipt/Proof-Of-Use/Disposition, Controlled Drug Record Individual Patient's Narcotic Record and Controlled Drug Receipt/Proof-Of-Use/Disposition forms, revealed facility staff do not have a uniformed and organized system to record narcotics administered to residents.