STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676005	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Place Nursing & Rehabilitation Center	2450 E Fifth St Tyler, TX 75701

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from physical abuse for 1 of 4 residents reviewed for abuse. (Residents #1)The facility failed to ensure Resident #1 was free from physical abuse when on 05/02/25 Resident #2 grabbed Resident #1's shirt around the neck, stretching the fabric, and bit her hand. Resident #1 had a visible bite mark to the back of the left hand and redness to the chest. This failure could place residents at risk for emotional distress, fear, decreased quality of life, and further abuse.Findings included:Record review of a face sheet dated 11/20/25 indicated Resident #1 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included dementia (loss of cognitive functioning), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), depression (mental illness that negatively affects how you feel, the way you think and how you act), anxiety disorder (persistent and excessive worry that interferes with daily activities), and Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves). Record review of the MDS dated [DATE] indicated Resident #1 had clear speech, was able to make herself understood, could understand others, she had a BIMS of 9 out of 15 indicating she had moderately impaired cognition, and she had no behaviors. Record review of the MDS dated [DATE] indicated Resident #1 had clear speech, was able to make herself understood, could understand others, she had a BIMS of 8 out of 15 indicating she had moderately impaired cognition, and she had no behaviors.Record review of the care plan revised on 09/08/25 indicated Resident #1 had no indication of behaviors. Record review of Nurse Notes for Resident #1 indicated on 05/02/25 Incident Report:Date/Time of Incident: 05/02/2025 at 06:30pmLocation: 1st Floor Front Doorway near LobbyDetails of Incident:Patient sustained a visible bite mark measuring 4cm x 3.5cm on the posterior lateral (outside of the back side) aspect of the left hand, without skin break,during an incident involving physical and verbal aggression by another resident. The patient also presents with redness to the chest,with no visible scratches noted. The patient reports that the aggressor grabbed her shirt around the neck, visibly stretching thefabric, and would not release it before biting her hand. Immediately following the incident, the patient was visibly shaken, anxious,and tearful, reporting 5/10 pain to the chest and neck. PRN tramadol was administered for pain management, and the patientexpressed that the tramadol had a good effect, with her pain now rated at 1/10.Vital Signs: BP: 130/72 Pulse: 80 bpm Respirations: 20/min SpO2: 99% Temperature: 98 FPost-Incident Actions:The on-call supervisor and ADON were notified immediately. The patient was removed from the area, and breathing exercises wereencouraged to reduce anxiety. Staff and a resident friend provided emotional support by sitting with the patient. The patient's nextof kin (daughter) was notified by this nurse at approximately 8:00 PM; however, the phone call went unanswered, and a voicemailwas left. At 8:00 PM, I spoke with [name] NP, who gave a verbal order for 50mg hydroxyzine PRN every 8 hours for anxiety. Thepatient received her first dose at 8:00 PM. Following this, the patient is now sitting in the dining room with two friends, andadditional ice was provided to the left hand to apply for 5-10 minutes to reduce swelling and discomfort. Notably, bruises arebeginning to form on the posterior side of the left hand. Resident friends continue to offer the patient support.Ongoing Monitoring:Frequent checks are being conducted on the patient, and she appears to be doing better emotionally but remains somewhat anxious.This nurse will continue to monitor the patient with checks every 15 minutes to assess her emotional state and pain levels. Thecurrent pain level remains at 1/10, and the patient continues to express relief following the tramadol.Documentation and Handoff:The ADON and on-call supervisor are aware of the situation and subsequent actions taken. This information will be passed on duringthe next shift handoff for continued monitoring and care.Conclusion:This nurse will continue to provide support, monitor the patient's condition, and document any changes. The situation will be closelymonitored, and further updates will be provided as necessary.The note was signed by LVN A.Record review of an Incident/Accident Report dated 05/02/25 indicated Resident #1 .sustained a visible bite mark measuring 4cm x 3.5cm on the posterior lateral aspect of the left hand, without skin break, during an incident involving physical and verbal aggression by another resident. [Resident #1] also presents with redness to the chest, with no visible scratches noted. [Resident #1] reports that the aggressor grabbed her shirt around the neck, visibly stretching the fabric, and would not release it before biting her hand. Following the incident, [Resident #1] was visibly shaken, anxious, and tearful, reporting 5/10 pain to the chest and neck. PRN tramadol was administered for pain management, and [Resident #1] expressed that

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, to the State Survey Agency, for 1 (Resident #6) of 4 residents reviewed for reporting allegations of abuse. The facility failed to report an allegation of abuse within 2 hours to the State Agency when Resident #6 reported to PTA J he was left on the bedpan too long and felt like he was abused. This failure could place residents at risk of abuse, physical harm, mental anguish, and emotional distress.Findings included: Record review of a face sheet dated 11/20/2025 indicated Resident #6 was a [AGE] year-old male, admitted to the facility on [DATE]. His diagnoses included unspecified atrial fibrillation (a type of irregular heartbeat), cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump), muscle weakness, peripheral disease (a blood circulation disorder that causes the blood vessels outside of the heart and brain to narrow, block, or spasm) extended spectrum beta lactamase (ESBL) resistance (enterobacterales are a group of bacteria that cause infections in healthcare settings and communities) and pneumonitis due to inhalation of food and vomit (a condition that occurs when foreign substances such as food, liquids, or stomach contents are inhaled into the lungs. This can lead to inflammation and irritation in the lungs, affecting the ability to breathe properly). Record review of a MDS admission assessment dated [DATE] indicated Resident #6 was able to make himself understood and understood others. He had a BIMS of 15 (intact cognitively). He had no behaviors identified. He required maximum assistance for toileting hygiene, shower/bathing and lower body dressing and moderate assistance with upper body dressing, and personal hygiene. He was always incontinent of bowel and bladder. Record review of Resident #6's care plan dated 10/13/2025 indicated Resident #6 had limited mobility, bowel/bladder incontinence and he required the support of one-person physical assist for toilet use. Record review of Resident #6's grievance form dated 11/13/2025 at 3:28 p.m. authored by PTA J reflected Resident #6 stated he is often left on his bedpan for long periods of time and reports it was 90 minutes yesterday and states this is abuse. Record review of TULIP (online system for submitting long-term care incidents and complaints) indicated the facility did not report the allegation of abuse on 11/13/2025.During an interview on 11/19/2025 at 2:00 p.m., PTA J said during Resident #6's therapy session on 11/13/2025 he reported to him that he felt like he was abused because he was left on his bedpan for long periods of time on 11/12/2025. He said Resident #6 said the incident occurred 11/12/2025 but he did not inform anyone until telling him on 11/13/2025. He said that he sent an electronic message to the management team and notified the Administrator of the report immediately.During an interview on 11/19/2025 at 2:15 p.m., CNA G said he does not recall Resident #6 but if a resident is placed on the bedpan around shift change or last rounds that he checks with the resident before leaving the hall or notifies the oncoming shift that the resident is on the bedpan. He said he would leave the call light nearby and tell the residents to call when they needed to be removed or assistance. He said he has been trained on abuse and neglect and was aware of reporting any allegations of abuse to the Administrator/Abuse Prevention Coordinator immediately.During an interview on 11/19/2025 at 3:30 p.m., the DON said that she received an electronic message from PTA J reporting that Resident #6 had stated to him that he felt like he had been abused by facility staff because he was left on the bedpan too long 11/12/2025. She said she and the Administrator immediately went and interviewed Resident #6. She said that Resident #6 declined being abused and acknowledged he was frustrated because of loss of independence. She said Resident #6 said he had requested the bedpan at shift change and the outgoing staff checked on him prior to leaving the shift but he was not finished, so he had to wait a little longer for oncoming staff to remove him from the bedpan. She said he denied abuse and said he felt safe at the facility. She said he was apprehensive about his upcoming discharge and providing self-care at home. She said allegations of abuse should be reported to the Administrator/abuse coordinator immediately, so the appropriate authorities (local police, state agencies, ombudsman, family) could be notified during the required timeframe. During an interview on 11/19/2025 at 4:00 p.m., the Administrator said that he received an electronic message from PTA J that Resident #6 had made a statement regarding being abused. He said he and the DON immediately went to interview Resident #6. He said that Resident #6 declined being abused and acknowledged he was frustrated because of loss of independence. He said Resident #6 said he had requested the bedpan at shift change and the outgoing staff checked on him prior to leaving the shift but he

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care within 48 hours of a resident's admission and provide the resident and their representative with a summary of the baseline care plan for 4 of 21 residents (Resident #4, #5, #12 and #15) reviewed for new admissions. 1. The facility did not provide a copy of the baseline care plan to Resident #4 or their representative. 2. The facility to develop and accurately complete a baseline care plan within 48 hours of admission for Resident #5, #12, and #15. This failure could lead to residents not receiving necessary care and decreased quality of life.1. Record review of a face sheet dated [DATE] indicated Resident #4 was a [AGE] year-old male admitted on [DATE]. His diagnoses included respiratory failure (a serious condition that makes it difficult to breathe on your own), depression (mental illness that negatively affects how you feel, the way you think and how you act), post-traumatic stress disorder (mental health condition that's triggered by a terrifying event - either experiencing it or witnessing it), hypertension (a condition in which the force of the blood against the artery walls is too high), heart failure (a condition that develops when the heart doesn't pump enough blood for the body's needs), chronic obstructive pulmonary disease (lung disease that blocks airflow making it difficult to breathe), benign prostatic hyperplasia (noncancerous enlargement of the prostate gland), and obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow and can be either structural or functional). Resident #4 expired on [DATE]. Record review of a Baseline Care Plan dated [DATE] reflected it had no indication it was provided to Resident #4 or the RP.During an interview on [DATE] at 10:39 a.m. the DON said she did not see where the BLCP was provided to Resident #4 or the RP after reviewing the previous EMR system. She said he expired before the new EMR system was put into place on [DATE] so it would not be in the new EMR system. 2. Record review of a face sheet dated [DATE] indicated Resident #5 was a [AGE] year-old male admitted on [DATE]. His diagnoses included type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), sepsis (potentially life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs), neoplasm of the prostate (non-cancerous enlargement of the prostate gland that commonly occurs in older men), atrial flutter (upper chambers of the heart beat faster than normal and are coordinated), anxiety disorder (persistent and excessive worry that interferes with daily activities), depression (mental illness that negatively affects how you feel, the way you think and how you act), and hypertension (condition in which the force of the blood against the artery walls is too high). Record review of a Baseline Care Plan for Resident #5 indicated the following: .B. Signature of Resident and Representative1. Resident signature and dateResident #5 [DATE]. C. Signatures of Staff Completing the Baseline Care Plan1. Signature of staff completing plan, title and dateLVN D [DATE].Record review of a Baseline Care Plan Acknowledgement for Resident #5 indicated a copy of the BLCP was provided to Resident #5 and to the RP on [DATE].Record review of a face sheet dated [DATE] indicated Resident #12 was a [AGE] year old female admitted on [DATE], and her diagnoses included mood disorder (mental disorders that primarily affect a person's emotional state), schizoaffective disorder (mental health condition with a combination of symptoms of schizophrenia and mood disorder), morbid (severe) obesity due to excess calories, diabetes (a chronic condition that affects the way the body processes blood sugar), general anxiety (persistent and excessive worry that interferes with daily activities), vascular dementia (a type of loss of cognitive functioning caused by conditions that damage blood vessels and block blood flow to your brain) and depression (mental illness that negatively affects how you feel, the way you think and how you act). Record review of admission MDS assessment dated [DATE] for Resident #12 indicated she was able to make herself understood and understood others, she was cognitively intact (BIMS score 13), she was at risk for developing pressure ulcers and was utilizing pressure reducing devices for bed and chair for skin ulcer and injury prevention. She was frequently incontinent with bowel and bladder. Record review of a base line care plan dated [DATE] for Resident #12 reflected it did not contain the following CMS guideline required information:*Precautionary plan for fall risk;*Dietary instructions for Diabetic diet;*Prescribed PRN (as needed) medications;*Prescribed routine medications;*Prescribed therapy services; and*Failed to provide Resident #12 with a summary of the baseline care plan.During an interview on [DATE] at 2:15 p.m., LVN H said she completed the admission on Resident #12 on [DATE] but did not have time to complete the nursing

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received care, consistent with professional standards of practice, to prevent pressure ulcers based on the comprehensive assessment for 7 of 21 residents (Resident #s 1, 8, 9, 10, 11, 12, and 14) reviewed for skin assessments. The facility failed to ensure Residents #1, #8, #9, #10, #11, #12, and #14 received a weekly skin assessment to identify risk of pressure injuries or existing pressure injuries.This failure could place residents at risk for developing unidentified pressure ulcers, could contribute to developing avoidable pressure ulcers and of not receiving adequate care and medical treatments to maintain skin integrity.Findings include:Record review of a face sheet dated 11/20/25 indicated Resident #1 was a [AGE] year-old female admitted on [DATE]. Her diagnoses included dementia (loss of cognitive functioning), type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), depression (mental illness that negatively affects how you feel, the way you think and how you act), anxiety disorder (persistent and excessive worry that interferes with daily activities), and Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves). Record review of the MDS dated [DATE] indicated Resident #1 had clear speech, was able to make herself understood, could understand others, she had a BIMS of 9 out of 15 indicating she had moderately impaired cognition, and she had no behaviors. Record review of the MDS dated [DATE] indicated Resident #1 had clear speech, was able to make herself understood, could understand others, she had a BIMS of 8 out of 15 indicating she had moderately impaired cognition, and she had no behaviors.Record review of the care plan revised on 11/22/2024 indicated Resident #1 was at risk for skin breakdown due to impaired mobility, incontinent of bowel and bladder and impaired skin. Record review of Resident #1's EMR reflected he did not have a skin assessment for the weeks of 11/03/2025 and 11/10/2025.Record review of Resident #8's face sheet dated 11/18/2025 indicated he was [AGE] years old, initially admitted on [DATE] and readmitted on [DATE], and his diagnoses included dementia (the loss of cognitive functioning - thinking, remembering, and reasoning - to such an extent that it interferes with a person's daily life and activities), Alzheimer's disease (progressive disease that destroys memory and other important mental functions), and cognitive communication deficit.Record review of Resident #8's quarterly MDS assessment dated [DATE] indicated he sometimes was able to make himself understood and usually understood others, had severe cognitive impairment (BIMS score 03), was utilizing pressure reducing device for bed and chair for skin ulcer and injury prevention. He was frequently incontinent with bowel and bladder. Record review of Resident #8's care plan dated 09/29/2025 indicated Resident #8 was at risk for pressure ulcers related to poor nutrition, and impaired skin integrity related to bowel/bladder incontinence and limited mobility related to dementia. Interventions included following facility policies/protocols for the prevention/treatment of skin breakdown, incontinent care after each episode and apply moisture barrier and notify nurse immediately of new skin breakdowns. Record review of Resident #8's EMR reflected he did not have a skin assessment for the weeks of 10/27/2025, 11/03/2025, and 11/10/2025.During an observation of Resident #8's skin assessment provided by WCN on 11/19/2025 at 4:15 p.m., skin color was normal, temperature of skin was warm, and no bruises, skin tears, abrasion, laceration, surgical incision, rash, moisture associated skin damage, pressure, venous, arterial or diabetic ulcer identified. Record review of Resident #9's face sheet dated 11/18/2025 indicated he was [AGE] years old, initially admitted on [DATE] and readmitted on [DATE], and his diagnoses included myocardial infarction (blood flow decreases or stops in one of the blood vessels of the heart causing tissue death), diabetes (a chronic condition that affects the way the body processes blood sugar) with neuropathy (type of nerve damage that can happen with diabetes), combined systolic (a condition in which the heart's main pumping chamber (left ventricle) is weak). and diastolic (a condition in which the heart's main pumping chamber (left ventricle) becomes stiff and unable to fill properly) heart failure, and cognitive communication deficit.Record review of Resident #9's significant change MDS assessment dated [DATE] indicated he usually was able to make himself understood and usually understood others, he was cognitively intact (BIMS score 14), he was at risk for developing pressure ulcers and was utilizing pressure reducing devices for bed and chair for skin ulcer and injury prevention. He was frequently incontinent with bowel and bladder.Record review of Resident #9's care plan dated 09/26/2025 indicated Resident #9 was at risk for impaired skin integrity related to bowel/bladder incontinence. Interventions included following facility policies/protocols for the prevention/treatment of skin

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and record review, the facility failed to establish a system of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and determine that drug records were in order and that an account of all controlled drugs were maintained and periodically reconciled for 3 of 3 medication carts (1st Floor North/East Medication Aide Cart, 1st Floor North (even)/East Nurse Cart, and 1st Floor North (odd)/West Nurse Cart) and 1 of 3 residents (Resident #3) reviewed for controlled medications.* LVN C did not sign out on Resident #3's narcotic count sheet for the hydrocodone/acetaminophen 5mg/325mg (narcotic pain medication) when she administered the medication on 11/19/25 or 11/20/25 during the night shift.* LVN C, RN B, and LVN D did not count the narcotics on the 1st Floor North/East Medication Aide Cart with during the shift change on 11/20/25 to ensure the count was correct.* LVN C and RN B did not count the narcotics on the 1st Floor North (even)/East Nurse Cart during the shift change on 11/20/25 to ensure the count was correct.* LVN C and LVN D did not count the narcotics on the 1st Floor North (odd)/West Nurse Cart during the shift change on 11/20/25 to ensure the count was correct.This failure could place residents at risk for medication overdose, medication under-dose, ineffective therapeutic outcomes, and drug diversion. Findings included: During an observation and interview on 11/20/25 at 06:43 a.m. MA E asked RN B to count Resident #3's bottle of hydrocodone/acetaminophen 5mg/325mg because the count was off by 1 tablet. When RN B counted the medication, it was one 1 tablet short. RN B said LVN C had told her she had given Resident #3 a hydrocodone/acetaminophen 5mg/325mg tablet on the 11/19/25 6p-6a shift. Record review of the narcotic count sheet for Resident #3 indicated there was no medication signed out for 11/19/25 or 11/20/25 by LVN C. During an interview on 11/20/25 at 06:45 a.m. MA E said she was late this morning and LVN C was already gone when she arrived, so she did not count the medication cart with her. RN B said she and LVN C did not count the Medication Aide cart before LVN C left. She said if the MA was not at work yet then the nurse should count with one of the other nurses. MA E said she counted the cart when she arrived and noticed the one medication was off by one tablet so she had RN B recount with her. During an interview on 11/20/25 at 07:22 a.m. LVN D said LVN C did not count the medication aide cart or her cart with her. She said they were supposed to count the narcotics when she comes on and before the night shift leaves. During an interview on 11/20/25 at 07:23 a.m. RN B said LVN C did not count her cart with her. She said she signed the shift count sheet because she counted her cart to ensure the count was correct. During an interview on 11/20/25 at 07:25 a.m. the ADON said the nurses and medication aides were expected to count narcotic medications during shift change. Record review of the Narcotic Drug Shift Count Sheets for November 2025 for the 1st Floor North/East Medication Aide Cart indicated there was no signature for:-10p-6a off going shift on1st through 6th, 9th through 15th, and 19th through 20th;- 6a-2p off going shift on 5th, 17th, and 18th;- 2p-10p off going shift on 14th and 16th; and- 10p-6a on coming shift on 1st through 5th, 8th through 14th, and 17th through 20th. Record review of the Narcotic Drug Shift Count Sheets for November 2025 for the 1st Floor North (even)/East Nurse Cart indicated there was no signature for:- 6p-6a off going shift on 8th, 12th, and 15th;- 6a-6p on coming shift on 17th and 18th;- 6a-6p off going shift on 10th, 17th, and 18th; and- 6p-6a on coming shift on 16th. Record review of the Narcotic Drug Shift Count Sheets for November 2025 for the 1st Floor North (odd)/West Nurse Cart indicated there was no signature for:- 6p-6a off going shift on 3rd, 8th, 16th, 17th, and 18th; - 6a-6p on coming shift on 3rd, 9th, 12th, 13th, 17th, 18th, and 20th;- 6a-6p off going shift on 3rd, 9th, 12th, 13th, 17th, and 18th; and- 6p-6a on coming shift on 1st, 2nd,7th, 14th, and 15th. During an interview on 11/20/25 at 09:56 a.m. the DON said she expected nurses and medication aides to count the narcotics at shift change. She said she was not aware of all the missing signatures from the shift count sheets. She said they figured out where Resident #3's hydrocodone/acetaminophen 5mg/325mg missing tablet went. She said she spoke with Resident #3 and she said she had received the medication when she requested it. She said LVN C was not able to be contacted at this time because she was asleep. During an interview on 11/20/25 at 10:28 a.m. the Administrator said staff were expected to count the narcotics at shift change. He said if they were not counted staff would be counseled and re-educated. He said there was the risk of drug diversion if not counted. Record review of a Controlled Substances policy dated 2001 indicated the following: Policy StatementThe facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule 11-V of the Comprehensive Drug Abuse Prevention and Control Act of 1976) Policy Interpretation and Implementation Handling Controlled