

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Town Hall Estates Whitney Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 San Marcus Whitney, TX 76692	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47772 Based on interview and record review, the facility failed to ensure each resident had the right to be free from misappropriation of property for 2 of 6 residents (Resident #1 and #2) reviewed for misappropriation of property. The facility failed to prevent the misappropriation of Resident #1's morphine sulfate (concentrate) solution 30 mg/ml, a medication to help with pain. This failure placed residents at risk for not receiving prescribed medications. Findings included: Record review of Resident #1's AR, dated 5/6/2024, reflected a [AGE] year-old female, who was admitted to the facility on [DATE]. She was diagnosed with Chronic Obstructive Pulmonary Disease (COPD, which was a respiratory condition characterized by persistent breathlessness and cough,) Alzheimer's Disease (which was a progressive disease having had caused mild memory loss, ability to carry on conversations, or the ability to respond to the environment,) and Heart Failure (which occurred when the heart muscle did not pump blood as well as it should.) Record review of Resident #1's Quarterly MDS, dated [DATE], reflected Section C., Cognitive Patterns: Resident had severe cognitive impairment. Section J., Health Conditions: Resident demonstrated non-verbal sounds, facial expressions, and protective body movements or postures as indicators of pain. Indicators of pain observed daily. Section N., Medications: Resident received anti-anxiety and opioid medications. Section O., Special Treatments: Resident was on Hospice while a resident. Record review of Resident #1's CP reflected a [Focused] area, initiated on 4/18/2024, evidenced for acute/chronic pain. The [Goal,] initiated on 4/18/2024, was that resident will not have interruptions in normal activities due to pain. The [Intervention,] initiated 4/18/2024, was that staff was supposed to anticipate the residents need for pain relief and would respond immediately to any complaint of pain. Staff was supposed to administer analgesia (pain medications) as per orders. Resident #1's CP reflected a second [Focused] area, initiated on 4/18/2024, evidenced with hospice to assist with pain management. The [Goal,] initiated on 4/18/2024, was that resident's comfort was to be maintained. The (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: 676074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Town Hall Estates Whitney Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 San Marcus Whitney, TX 76692	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[Intervention,] initiated 4/18/2024, was that staff was supposed to have observed the resident closely for signs of pain and having had administered pain medications as ordered. Resident #1's CP reflected a third [Focused] area, initiated on 4/18/2024, evidenced with resident having used anti-anxiety medications R/T anxiety disorder. The [Goal,] revised on 5/3/2024, was that resident's comfort was to be free from discomfort or adverse reactions related to anti-anxiety therapy. The [Intervention,] initiated 4/18/2024, was to administer medications as ordered. Record review of Resident #1's Order Summary Report, viewed on 5/6/2024, reflected the resident was ordered 1 (one) hydrocodone-acetaminophen tablet, 5-325 mg by mouth at bedtime, for pain; Ordered 3/01/2024. Resident was ordered .05 ml morphine sulfate (concentrate) solution 20 mg/ml by mouth every 1 hour as needed for pain or shortness of breath, may give sublingual; Ordered 2/26/2024. Resident was ordered 1 ml morphine sulfate (concentrate) solution 30 mg/ml by mouth every 1 hour as needed for pain or shortness of breath, may give sublingual; Ordered 2/26/2024. Resident was ordered 1 (one) lorazepam tablet (Ativan,) .5 mg tablet by mouth at bedtime for anxiety; Ordered 3/1/2024. Record review of Resident #2's AR, dated 5/6/2024, reflected a [AGE] year-old male, who was admitted to the facility on [DATE]. He was diagnosed with Vascular Dementia (which was a disease caused by a lack of blood which carried oxygen and nutrient to the brain,) Muscle Wasting and Atrophy (which was a condition that caused muscle decrease in size and ability,) and, Anxiety Disorder, (which was a mental heal condition marked by heightened responses to certain situations and stimuli.) Record review of Resident #2's Quarterly MDS, dated [DATE] reflected Section C., Cognitive Patterns: Resident had a BIMS Score of 10. A BIMS score of 10 indicated the resident had moderate cognitive impairment. Section N., Medications: Resident received antipsychotic and opioid medications. Section O., Special Treatments: Resident was on Hospice while a resident. Record review of Resident #2's CP reflected a [Focused] area, initiated on 12/25/2022 evidenced by depression R/T disease process. The [Goal,] revised on 11/01/2023, was that resident will remain free from symptoms of depression, anxiety, or sad mood. The [Intervention,] initiated 10/25/2022, was to administer medications as ordered. Record review of Resident #2's Order Summary Report, viewed 5-6-2024, reflected the resident was ordered 1 (one) lorazepam tablet, .5 mg tablet by mouth every 2 hours as needed for anxiety/agitation/restlessness; Ordered 4/9/2024. Record review of the local PD report (W-24-00895), dated 4/20/2024 at 12:24 PM, reflected a call from the facility to the PD related to diversion of a controlled substance for another person's use. The report detailed medications having been reported missing/taken, Morphine and Ativan (Lorazepam,) by the alleged perpetrator, LVN A. The report contained a supplemental narrative, dated 4/24/2024 at 2:52 PM, which indicated LVN A returned a specific medication, the bottle of morphine, to the facility. The medication bottle was returned with the correct amount of liquid, based on amount supposed to be left in the bottle after its last use on 4/19/2024, 29 ML. The supplemental report made no mention of the allegedly missing Lorazepam. The responding and reporting police officer was RRPO. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Town Hall Estates Whitney Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 San Marcus Whitney, TX 76692	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility's PIR, dated 4-26-2024, indicated an allegation of drug diversion occurred on 4/20/2024 at 7:20 AM; reported to the state offices on 4/20/2024 at 2:56 PM. The alleged victims were Resident #1, who allegedly had morphine sulfate and .5 MG lorazepam tablet misappropriated and Resident #2, who allegedly had .5 MG lorazepam tablet misappropriated. The alleged perpetrator was LVN A. LVN A was SKTAE. LVN A denied the allegation. No history of similar allegations; there was not an eyewitness. The PIR indicated no injury or adverse effect. An assessment, Pain in Advanced Dementia, was completed on 4/20/2024 at 3:00 PM by the ADON to determine the severity of pain experienced by the resident, who allegedly had their morphine sulfate misappropriated. Resident #1 displayed: normal breathing, no negative vocalization, smiling or inexpressive facial expression, relaxed body language, and no need to console. The assessment indicated the resident was not in pain. No treatment or transfer was applicable. 16-Safe surveys were completed on 4/25/2024; Pharmacy consultant performed pharmacy audit on 4/26/2024; No negative outcomes found. Police report W24-00895. Timeline for provider response: Confirmed Misappropriation on 4/20/2024, HHSC report started 10:00 AM, SKTAM informed at 11:14 AM, VP of operations informed at 12:10 PM, Hospice informed at 12:19 PM, RP informed at 1:00 PM, Physician and Medical Director informed at 2:43 PM. Statements attached for details of allegation. Record review of Resident #1's Medication Error Report, dated 4/20/2024, and record review of Resident #1's Narcotic Count Sheet, reflected the resident had bottle of 5 (five) .5 lorazepam and a medication card with 60 (sixty) .5 lorazepam as of 4/18/2024. *After an administration of 2 (two) lorazepam on 4/19/2024 at 1:00 AM from the medication card, the remaining count was allegedly incorrectly marked as 58 (fifty-eight.) The report alleged the card only had 56 (fifty-six) left, with 2 (two) .5 MG lorazepam missing. Count was corrected to reflect 56 remaining. *After an administration of 2 (two) lorazepam on 4/19/2024 at 10:00 PM from the bottle, the remaining count was allegedly incorrectly marked as 2 (two.) The report alleged the bottle only had 2 (two) left, with 1 (one) .5 MG lorazepam missing. Count was corrected to reflect 2 remaining. *After an administration of 1 ML of morphine sulfate (concentrate) solution, the remaining 29 ML bottle was missing from the medication cart. Record review of Resident #2's medication error report, dated 4/20/2024, and record review of Resident #2's Narcotic Count Sheet, reflected the resident had bottle of 11 (eleven) .5 lorazepam as of 4/9/2024. *After an administration of 2 (two) lorazepam on 4/18/2024 at 11:00 PM from the bottle, the remaining count was allegedly incorrectly marked as 9 (nine.) The report alleged the bottle only had 8 (eight) left, with 1 (one) .5 MG lorazepam missing. Count was corrected to 8 remaining. Record review of a staff's statement, written on 4/20/2024 (no time indicated) by CMA B, reflected that LVN A left the facility and that the CMA B retrieved the medication cart keys from the day nurse, RN. While inventorying the med cart, there was a discrepancy, a bottle of morphine sulfate (concentrate) solution 30 mg/ml was missing, and there were count discrepancies with 3 bottles of Lorazepam. The ADON was notified. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Town Hall Estates Whitney Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 San Marcus Whitney, TX 76692	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of a staff's statement, written on 4/20/2024 (no time indicated) by LVN C, reflected that the narcotic count was correct last night (no specific shift indicated.) LVN C stated she did not administer Lorazepam or Morphine to Resident #1 or Resident #2. Record review of a staff's statement, written on 4/20/2024 (no time indicated) by RN, reflected LVN A did not provide a full report from the previous 10-6 shift (no specific times or date indicated.) LVN A gave RN the medication cart keys. RN spoke to CMA B about checking the narcotic cart. Record review of a staff's statement, written on 4/20/2024 (no time indicated) by SM, reflected the SM left the facility at 10:00 PM on 4/19/2024. SM stated the narcotic count was accurate. SM did not administer Morphine or Lorazepam to Resident #1; did not give Resident #2 Lorazepam. Record review of a staff's statement, written on 4/20/2024 (no time indicated) by CNA D, reflected CNA D heard the 300-hallway door alarm making an audible alert. CNA D approached the 300-hallway door to see LVN A at the door. CNA D opened the door. LVN A showed CNA D a bottle of morphine and stated she needed to see the ADON and return it. LVN A went to the nurse's station and talked to the RN and the ADON on the phone. Record review of a staff's statement, written on 4/20/2024 (no time indicated) by RN, reflected LVN A came into the facility through side door, on 4/20/2024 at 9:45 PM, holding a medication bottle having said she wanted to return it. RN called the ADON to inform. Bottle was placed in biobag and placed in lock box. Record review of a staff's statement, written on 4/20/2024 (no time indicated) by LVN E, reflected LVN A came into the facility through side door, on 4/20/2024 at 9:40 PM, with the assistance of CNA D. LVN A walked up to the nurse's station to let them, LVN E and the RN, know that she had accidentally taken the morphine. Record review of a staff's statement, written on 4/22/2024 (no time indicated) by the ADON, reflected a timeline of text messages and calls pertaining to the 10-6 shift on 4/19/2024. On 4/20/2024 at 6:49 AM, received text from RN that LVN A did not sign out her medication. On 4/20/2024 at 7:04 AM, received text from RN that CMA B reported missing morphine. On 4/20/2024 at 7:30 AM, the ADON called LVN A (no call information provided). On 4/20/2024 at 7:47 AM, the ADON texted LVN A about missing narcotics (no call information provided.) On 4/20/2024 at 3:50 PM, the ADON called and spoke with LVN A about missing narcotics. ADON stated that LVN A stated she did medication pass and the morphine was in the med cart. In response, the ADON stated she, the ADON, had watched the videos and did not see her, LVN A, performing med pass. On 4/20/2024 at 9:43 PM, missed a call from LVN A. On 4/20/2024 at 9:45 PM, received a call from RN. RN stated LVN A was at the facility with the bottle of morphine and wanted to speak with the ADON. LVN A [said she found the bottle of morphine in her pocket when she was doing laundry.] The ADON claimed LVN A was trying to justify her actions; The ADON told LVN A, I have already reported to the police and the state, you can tell them. Record review of LVN A Quick Conform License Verification Report, dated 4/20/2024 at 12:57 PM indicated LVN A's license was active and unencumbered to practice by the state board of nursing. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Town Hall Estates Whitney Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 San Marcus Whitney, TX 76692	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of 19 undated safe surveys reflecting responses for 3 questions, to which all posed no concerns for regulatory non-compliance. Questions were: 1. How are you doing? 2. How are you being treated. 3. Have you had any pain recently? If so, did you get relief? Record review of Resident #1's progress note, dated 4/20/2024 at 6:48 PM, reflected a nursed note, which indicated a follow up note with residents who have admitted within 72 hours. The progress noted the resident had been medicated for pain and anxiety per orders. No adverse reaction. Written by RN. Progress note, dated 4-21-2024 at 5:37 AM, reflected a Skilled Evaluation, which reflected the resident displayed no indicators of pain. Written by LVN C. Record review of an email communication from SKTAM, dated 4/24/2024 at 9:46 PM, relayed gratitude to the ADON at the facility for the information pertaining to alleged drug diversion on 4/20/2024. SKTAM wrote that LVN A had been deactivated from SKTA pending state investigation. A drug screen had been ordered for LNV A. Record review of the facility's QAPI team minutes, dated 4/26/2024 at 2:00 PM, reflected the accounts of the alleged drug diversion on 4/20/2024 and drug diversion chosen for a PIP. Chairperson of the QAPI meeting was the ADM. Record review of a Consultant Pharmacist Report, dated 4/26/2024 and signed by PHC, reflected: 1. The facility requested a review of the controlled substances and related documentation; 2. All controlled substances in the two medication carts and the lock box and the medication room refrigerator were counted with the medication aide on duty. No discrepancies were identified; 3. All controlled drug sheets were checked for possible patterns of inappropriate use. No such indications were identified; 4. The DON indicated that in services were performed with staff having regard it to shift change control drug counts, medication administration, medication cart security, and ANE related procedures; 5. All open the morphine that was in use at the time of the possible diversion were replaced with fresh supplies in case of possible adulteration. Record review of Specimen Result Certificate from LC dated 5/1/2024 at 10:35 PM, reflected LVN A submitted a urine sample on 4/30/2024. The results were negative for Marijuana, Cocaine, Amphetamines, Opiates, Propoxyphene, PCP, Barbiturates, Benzodiazepines, Methaqualone, and Methadone. Final Drug Disposition: NEGATIVE. Signed by LCMD on 5-1-2024 at 10:34 PM Observation and interview on 5-6-2024 at 10:15 AM reflected Resident #1 in her wheelchair near the nurse's station. She was fully dressed and well groomed. There were no body odors, urine odors, or bowel odors. When asked, Resident #1 stated she was doing fine. She made eye contact and responded in a pleasant tone. She did not appear to be in any distress; she did not appear to be in any pain. Observation and interview on 5-6-2024 at 10:40 AM with LVN C reflected an accurate count of controlled substances in the medication room. She stated that it was facility policy to count medication at the beginning and the end of each shift for accountability. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Town Hall Estates Whitney Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 San Marcus Whitney, TX 76692	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5-6-2024 at 1:20 PM with LVN E revealed she was on shift the night of 4/20/2024. While at the nurse's station, close to 9:40 PM, she stated heard audible tones coming from the side door of the 300-hallway. Moments later, LVN A presented at the nurse's station. She was observed to have removed, what was supposedly a bottle of morphine, from her pocket. She was heard having stated [I have it right here.] LVN E stated she observed, and heard, LVN A talk to the ADON on the telephone. LVN A overheard LVN A state [I realized it was in my pocket while I was doing laundry, brought it here straight away.] Interview on 5-6-2024 at 2:05 PM with the ADON revealed that she received a phone call from the facility on 4/20/2024 close to 9:45 PM from the RN. She was informed that LVN A returned the supposed bottle of morphine to the facility. Then RN put LVN A on the phone with the ADON at that time. The ADON stated LVN A wanted her to know that she had returned the bottle to the facility. Interview on 5-6-2024 at 2:20 PM with CNA D revealed he witnessed LVN A trying to get into the building using the door at the end of the 300 hallway. He assisted her entering the door, where she stuck out her arm in the doorway and in her hand was supposedly a bottle of morphine. CNA D stated she said [I have to return this morphine.] He observed LVN A approach the nurse's station and observed LVN A give the supposed bottle of morphine to the RN. He stated he overheard the phone call conversation between LVN A and the other caller, the ADON, which he heard LVN A state [I was going through my laundry and noticed I had this bottle of morphine.] Interview on 5-6-2024 at 3:00 PM with LVN A revealed she worked the overnight shift from 10:00 PM on 4/19/24 until 6:00 AM on 4/20/2024. She was unable to recall if she had worked the overnight shift from 10:00 PM on 4/18/2024 to 6:00 AM on 4/19/2024. She stated she had observed her resident, Resident #1, having displayed behaviors of pain. She stated she pulled a dose of liquid morphine out of the bottle and placed the bottle in her pocket. She then administered the medication and had gone on about her work for the rest of the shift. She stated she was exhausted from work and went home after her shift and went straight to bed. It was not until later, when she was doing her laundry, that she realized she left the facility with Resident #1's morphine in her possession. LVN A denied consuming any of the morphine and denied taking the morphine for anyone else's use. She did not remember administering lorazepam to any residents. She denied consuming any of the lorazepam. She denied taking any lorazepam for anyone else's use. She took a drug text on 4-30-2024 and it was negative for all substances tested . Interview on 5-6-2024 at 3:30 PM with RN H revealed she was Resident #1's nurse. On 4/20/2024, she was made aware of a staff member allegedly having walked out of the facility with Resident #1's morphine medication. 4/20/2024 was a Saturday and RN H arranged the facility to use their pharmacy to get a new bottle of morphine for Resident #1. The replacement bottle made it to the facility that same day in the evening hours. RN H stated the resident's pain was well controlled with hydrocodone-acetaminophen tablet, 5-325 mg by mouth at bedtime, and the morphine was only on hand for extreme cases. Resident #1 did not have a long-standing history of use with the morphine. The RN H was not concerned for Resident #1's safety at any time because she had her primary medication for pain. If the resident did have an episode of pain, which was uncontrollable with the hydrocodone-acetaminophen tablet, she may have needed the morphine. Without the morphine on hand, Resident #1 risked increased pain, frustration, increased vitals, anger, anxiety, or the need to be taken to the ER. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676074	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/06/2024
NAME OF PROVIDER OR SUPPLIER Town Hall Estates Whitney Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 101 San Marcus Whitney, TX 76692	
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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5-6-2024 at 4:00 PM with the DON revealed the facility had a policy in place to address medications being used for a different person, being taken for personal use, or even leaving the facility's premises. She stated LVN A violated facility policy by leaving the facility with Resident #1's medication. There were safeguards in place to stop this type of incident from happening, and those safeguards were shift-change medication counts and random counts for medications. The DON stated Resident #1 was not placed in any harm due to the medication being removed from the facility because she had other primary pain medications. If Resident #1 did not have her primary pain medications and her morphine was not at the facility, Resident #1 risked uncontrolled pain, falls, and poorer appetite. Interview on 5-6-2024 at 4:15 PM with the ADM revealed the facility did have policies in place to address controlled substance counts and drug diversion. LVN A did violate facility policy by not counting her medication with the oncoming staff member and by removing Resident # 1's medication from the facility. The ADM did not believe Resident #1 was in any harm, because she had her primary pain medication on hand. Record review of a facility's in-service training for ANE, dated 4-5-2024, reflected misappropriation of property was having taken, having transferred, or having attempted transfer, to any person not entitled to receive any property, real or personal, or anything of value belonging to, or under the legal control of the resident, without the effective consent of the resident or the appropriate legal authority. LVN A's signature was not on the list for employees having attended. Record review of the facility's policy [Controlled Substances,] dated December 2012, indicated nursing staff was supposed to count controlled medications at the end of each shift. Nurses that came on duty, and the nurse going off duty, were supposed to count together; both were supposed to have documented and reported any discrepancies to the DON. The DON was supposed to investigate any discrepancies of narcotic counts, with a written report of such findings given the administrator, then the DON was supposed to consult with the provider, pharmacy, and the administrator to determine whether any further legal action was indicated. Record review of the facility's policy [Drug Diversion,] undated, indicated drug diversion, theft, was prohibited. Suspected drug diversion was supposed to be investigated and in the event that substantial evidence supported a belief the drug diversion had occurred, appropriate disciplinary and reporting actions were supposed to be taken. The facility defined drugs as any substance used in the diagnosis, treatment, or prevention of the disease. The facility defined diversion as theft of facility drugs, having included use, unauthorized possession, or unauthorized removal from the premises.		