STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676274	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Remarkable Healthcare of Seguin	1339 Eastwood Dr Seguin, TX 78155

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** 42031 Based on observation, interview, and record review the facility failed to ensure the resident's right to be free from misappropriation of resident property for 1 of 3 residents (Resident #1), reviewed for drug diversion. Resident #1's scheduled narcotic pain medication, 81 tablets (2 pharmacy cards) went missing from the medication cart and was never found. This failure could place residents at risk of misappropriation, and could result in increased pain, and poor quality of life. The findings were: Record review of Resident #1's face sheet dated 7/3/24 revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] with readmission on 4/1/2020. His diagnoses included alcohol dependence with alcohol induced persisting dementia (form of dementia caused by long-term, excessive consumption of alcohol, resulting in neurological damage and impaired cognitive function.), Type 2 diabetes with other circulatory problems (chronic condition that affects the way the body processes blood sugar and has caused circulation-blood flow problems), and chronic pain (long standing pain that persists beyond the usual recovery period or occurs along with a chronic health condition). Record review of Resident #1's annual MDS assessment dated [DATE] had no BIMS score documented, had chronic pain with no pain assessment completed and he received scheduled pain medication and no as needed pain medication. Record review of Resident #1's quarterly MDS assessment dated [DATE] had a BIMS score of 14 indicating the resident was cognitively intact . Record review of Resident #1's care plan undated revealed a focus for the resident had chronic pain with a risk of uncontrolled pain with a goal the resident will verbalize adequate pain control. Interventions included to monitor effectiveness and side effects of scheduled pain medication three times daily and notify the physician. Record review of Resident #1's EHR physician orders revealed an order with a revised date of 2/29/24 with a start date of 6/13/24 for norco oral tablet 10mg-325mg (hydrocodone-acetaminophen) three times daily. (is a combination opioid pain medication used for treating moderate to severe pain). (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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(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 Resident #1's EHR physician orders revealed an order with a start date of 5/21/19 for Tylenol 325mg tabs (acetaminophen) give 2 tablets (650mg) every 4 hours as needed for pain or temp >100 degrees. Record review of the facility self-report intake received 6/13/24 revealed LVN A notified the DON at 5:30 a.m. on 6/13/24 Resident #1's norco 10-325mg was missing from the narcotic lock box on the medication cart and could not be located. And all staff on 10p-6a shift and the 2p-10p medication aide had been drug tested . The MD was notified and a new triplicate prescription was requested. Pharmacy was also notified to bill the facility for the replacement and the police were notified. Record review of the facility investigation revealed all staff drug tested were negative. LVN A had reported not counting the narcotics with the off-going Medication aide but took the keys to the cart. There were 2 pharmacy cards of norco 10-325 that had been delivered on 6/7/24 and totaled 87 pills. The first card of 60 had 54 pills left with 6 of them being documented as administered. The second card of 27 had all 27 pills which equaled a total 81 pills remaining that were missing. The narcotic sign out sheets for these 2 cards remained in the narcotic sign out book. In-services were conducted on counting narcotics, reporting discrepancies, not leaving keys to medication carts unattended. Record review of Resident #1's EMAR for June 2024 revealed norco 10-325 tablets were scheduled to be given three times daily at 5:00 a.m., 1:00 p.m., and 8:00 p.m The resident did not receive his doses on 6/13/24 at 5:00 a.m., 1:00 p.m., or 8:00 p.m. and on 6/14/24 at 5:00 a.m Documentation the resident received all other doses scheduled for June 2024. Further review revealed Resident #1 was administered 2 Tylenol 325mg tabs on 6/13/24 at 5:10 a.m. by LVN A with a pain level of 0. During an observation and interview on 7/3/24 at 5:15 a.m., LVN B was outside of Resident #1's room and stated she needed to give the resident his medication and would be available after. LVN B stated she had given Resident #1 his pain medication norco as scheduled. During an observation on 7/3/24 at 6:04 a.m. of the 800-hall med cart narcotic count between LVN B and CMA E. LVN B was calling out the resident's last name and narcotic count number and CMA E was viewing the card confirming and moving to the next card. No verification of the medication or dosage was observed. LVN B and CMA E signed the count was correct. During an observation and interview on 7/3/24 at 6:09 a.m., of the 600-hall med cart narcotic count between LVN B and CMA E again calling out the resident's name and amount of drug but not verifying the dosage or the medication. When LVN B came to Resident #1's norco 10-325mg tabs the count was not correct and she stated she had not signed out for his 5:00 a.m. dose and stated she normally signs out when she pops the medication but surveyor's arrival made her forget. LVN B signed out for the norco 10-325mg tabs while surveyor and CMA E observed and the count was then verified as correct. During an observation on 7/3/24 at 6:10 a.m., of the treatment/PRN cart narcotic count between LVN B and RN D. LVN B was calling out the resident's name and amount of drug and RN D was stating name and dosage of drug, the count was correct without issues or concerns to include morphine solutions. (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 7/3/24 at 6:15 a.m., of the 800-hall nurse cart narcotic count between LVN B and LVN I. LVN B was calling out the resident's last name, drug, dosage, and amount left and LVN I was verifying on the drug card. LVN B stated she was flagging a med for a resident and stated she needed to sign out for it but needed to verify the time she gave it. LVN B flagged the narcotic sheet in the binder. LVN B went behind the nurses station to check the time she administered the medication. At 6:22 a.m. The narcotic sheet remained flagged and LVN I was observed signing the narcotic book that the count was correct. LVN I confirmed that she had just signed the narcotic count was correct with the narcotic sheet still flagged and when asked if she normally signed the shift narcotic count sheet when it was not correct LVN B and LVN I both stated LVN B was currently fixing the issue. LVN B then stated it was given at 4:32 a.m. and signed the narcotic count sheet that she gave it at 4:30am and unflagged the narcotic sheet. During an observation and interview on 7/3/24 at 8:25 a.m., Resident #1 was self-propelling in his wheelchair to his room from the dining room. The resident was dressed in decorative pajama pants and a shirt with slippers. In the resident's room when asked about the previous incident with his missing pain pills the resident stated, you're here for something that happened 3 months ago? I explained it happened in June as reported to us and the resident stated, I don't know. I asked the resident about his missed doses of his pain medication and if he had been in pain when he missed the 4 doses of his pain medication and the resident stated of course I was in pain, that's why I take them when asked the resident for a number on the pain scale or what level of pain, mild, moderate, or severe the resident turned his head, sighed loudly and stated I don't know the resident then turned away from surveyor and would not speak after that. This surveyor excused themselves and thanked the resident for his time. As this surveyor was leaving the room the resident stated, oh Lord why me . In an interview on 7/3/24 at 5:20 a.m., LVN B stated she Counted narcotics with the off-going CMA, and nurses and there were no narcotic count issues, and will count with the on-coming shift CMA and nurses. LVN B denied any knowledge of any staff doing drugs at the facility or any knowledge of drug diversion or missing narcotics at the facility beyond the one reported incident for Resident #1. In an interview on 7/3/24 at 5:31 a.m., CNA F denied any knowledge of staff taking narcotics or narcotics being an issue, stated she was aware of issue with Resident #1's narcotic pain medication but not since that time, CNA F denied any knowledge of ANE, misappropriation, or drug diversion at the facility. In an interview on 7/3/24 at 5:33 a.m. CNA G denied any knowledge of any narcotic count issues besides the previous incident with Resident #1's narcotic. CNA G denied any knowledge of ANE or any staff doing drugs at the facility or any knowledge of drug diversion at the facility and would report it if she did. In an interview on 7/3/24 at 5:40 a.m., LVN C stated he had no narcotic issues on his side of the building, denied any knowledge of staff doing drugs at the facility, or ANE, misappropriation, or drug diversion at the facility. In an interview on 7/3/24 5:45 a.m., CNA H denied any knowledge of narcotic issues or knowledge of any staff doing drugs at the facility. Denied any knowledge of ANE, misappropriation, or drug diversion at the facility. (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/3/24 at 6:12 a.m., CMA E stated the way they counted this morning was the normal way but usually they call out the drug name and dosage as well and then stated the count this morning was how they normally do it. Denied any knowledge of missing narcotics other than the incident for Resident #1 and denied any knowledge of ANE, misappropriation, or drug diversion at the facility. In a telephone interview on 7/3/24 at 10:34 a.m., LVN A stated she was the nurse for Resident #1 on the night of 6/12/24-6/13/24 and had discovered the missing narcotics for Resident #1 when she went to administer his 5:00 a.m. dose on 6/13/24 and she notified the DON immediately. LVN A stated the scheduled narcotics were on the CMA cart, when she got ready to do the med pass the sheets were there but the narcotic was not. LVN A stated the CMAs leave at 10pm and she keeps the keys for the CMA carts. LVN A stated she did not count with the CMA J prior to her leaving because she was tending to a Resident and CMA J had told her the count was correct and handed her the keys. LVN A stated she left for 10 minutes to get a soda but still had all the keys. LVN A stated she did leave the keys to the CMA carts in the drawer at the nursing station when she went to the bathroom because she had too many keys in her pockets to all the carts. Denied any knowledge of who took the medication. LVN A further stated she will lock the keys up in the medication room or in her cart if she doesn't have room in her pockets and will not leave them in drawers anymore and stated she knew she should have counted and not left the keys unattended. LVN A further stated she had no idea who could have taken Resident #1's narcotic medication and she was only gone for a few minutes and she does not know if the count was truly correct when she received the keys to the cart. In a telephone interview on 7/3/24 at 10:46 a.m., CMA J stated she was the off-going CMA and she had counted with the nurse when she came on duty on 6/12/24 and the count was correct for the start of her shift, CMA J stated LVN A was busy with a readmission, so she counted by herself when she left at 10:00 p.m. and it was the normal procedure and she handed the keys to LVN A and told her the count was correct and left. CMA J stated it was the normal routine for the CMAs to count by themselves but the narcotics were just put on the CMAs cart and Resident #1 had not complained of pain. CMA J denied taking any medications and stated she does not know what happened to them. CMA J further stated the nurse always counts with the CMA now and further stated she should have counted with another nurse if LVN A was busy. In an interview on 7/3/24 at 1:57 p.m., LVN I denied any issues with narcotics missing except for Resident #1's incident. Denied any knowledge of ANE, misappropriation, or drug diversion at the facility and further stated she was counting narcotics on-coming and off-going for her shifts. In an interview on 7/3/24 at 2:43 p.m., the DON stated the harm of the resident's pain medication missing could have been the possibility of pain. The DON confirmed Resident #1 missed 4 doses total of his norco scheduled pain medication. The DON further stated if Resident #1 had stated he had pain they could have contacted the physician for an alternate pain medication that does not require a triplicate prescription until his norco could be obtained from the pharmacy. The DON further stated he was assessed by the charge nurse and the DON and had stated he was not in pain . Review of the facility personnel records revealed background checks were completed as required for all staff on duty that evening (LVN A, CMA J, CNA F, and CNA G) (continued on next page)

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy on reporting ANE revised December 2006 indicated . Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Review of the facility policy on controlled substances revised December 2010 indicated . 5. Controlled substances must be stored in the medication room in a locked container, separate from containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtain medications for residents. 6. All keys to controlled substance containers shall be on a single key ring that is different from any other keys. 7. The Charge Nurse on duty will maintain the keys to controlled substance containers. The Director of Nursing Services will maintain a set of back-up keys for all drug storage areas including keys to controlled substance containers. 1. Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42031 Based on observation, interview, and record review the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident for 1 of 3 residents (Resident #1) reviewed for pharmacy services. Resident #1's narcotic pain medication was not counted as required, the keys to the medication cart left unsecured, and resulted in 81 tablets being drug diverted and the resident missed 4 doses of his scheduled pain medication . This failure could place residents at risk of misappropriation by drug diversion, and could result in increased pain, and poor quality of life. The Findings were: Record review of Resident #1's face sheet dated 7/3/24 revealed the resident was an [AGE] year-old male admitted to the facility on [DATE] with readmission on 4/1/2020. His diagnoses included alcohol dependence with alcohol induced persisting dementia (form of dementia caused by long-term, excessive consumption of alcohol, resulting in neurological damage and impaired cognitive function.), Type 2 diabetes with other circulatory problems (chronic condition that affects the way the body processes blood sugar and has caused circulation-blood flow problems), and chronic pain (long standing pain that persists beyond the usual recovery period or occurs along with a chronic health condition). Record review of Resident #1's annual MDS assessment dated [DATE] had no BIMS score documented, had chronic pain with no pain assessment completed and he received scheduled pain medication and no as needed pain medication. Record review of Resident #1's quarterly MDS assessment dated [DATE] had a BIMS score of 14 indicating the resident was cognitively intact. Record review of Resident #1's care plan undated revealed a focus for the resident had chronic pain with a risk of uncontrolled pain with a goal the resident will verbalize adequate pain control. Interventions included to monitor effectiveness and side effects of scheduled pain medication three times daily and notify the physician. Record review of Resident #1's EHR physician orders revealed an order with a revised date of 2/29/24 with a start date of 6/13/24 for norco oral tablet 10mg-325mg (hydrocodone-acetaminophen) three times daily. (is a combination opioid pain medication used for treating moderate to severe pain). Record review of Resident #1's EHR physician orders revealed an order with a start date of 5/21/19 for Tylenol 325mg tabs (acetaminophen) give 2 tablets (650mg) every 4 hours as needed for pain or temp >100 degrees. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility self-report intake received 6/13/24 revealed LVN A notified the DON at 5:30 a.m. on 6/13/24 Resident #1's norco 10-325 were missing from the narcotic lock box on the medication cart and could not be located. And all staff on 10p-6a shift and the 2p-10p medication aide had been drug tested . The MD was notified and a new triplicate prescription was requested. Pharmacy was also notified to bill the facility for the replacement and the police were notified. Record review of the facility investigation revealed all staff drug tested were negative. LVN A had reported not counting the narcotics with the off-going Medication aide but took the keys to the cart. There were 2 pharmacy cards of norco 10-325 that had been delivered on 6/7/24 and totaled 87 pills. The first card of 60 had 54 pills left with 6 of them being documented as administered. The second card of 27 had all 27 pills which equaled a total 81 pills remaining that were missing. The narcotic sign out sheets for these 2 cards remained in the narcotic sign out book. In-services were conducted on counting narcotics, reporting discrepancies, not leaving keys to medication carts unattended. Record review of Resident #1's EMAR for June 2024 revealed Norco 10-325 tablets were scheduled to be given three times daily at 5:00 a.m., 1:00 p.m., and 8:00 p.m. The resident did not receive his doses on 6/13/24 at 5:00 a.m., 1:00 p.m., or 8:00 p.m. and on 6/14/24 at 5:00 a.m Documentation the resident received all other doses scheduled for June 2024. Further review revealed Resident #1 was administered 2 Tylenol 325mg tabs on 6/13/24 at 5:10 a.m. by LVN A with a pain level of 0. During an observation on 7/3/24 at 6:04 a.m., of the 800-hall med cart narcotic count between LVN B and CMA E. LVN B was calling out the resident's last name and narcotic count number and CMA E was viewing the card confirming and moving to the next card. No verification of the medication or dosage was observed being done. LVN B and CMA E signed the count was correct . During an observation and interview on 7/3/24 at 6:09am of the 600-hall med cart narcotic count between LVN B and CMA E again calling out the resident's name and amount of drug but not verifying the dosage or the medication. When LVN B came to Resident #1's norco 10-325 tabs the count was not correct and she stated she had not signed out for his 5:00 a.m. dose and stated she normally signs out when she pops the medication but surveyor's arrival made her forget. LVN B signed out for the norco 10-325mg tabs while surveyor and CMA E observed and the count was then verified as correct. During an observation and interview on 7/3/24 at 6:15am of the 800-hall nurse cart narcotic count between LVN B and LVN I. LVN B was calling out the resident's last name, drug, dosage, and amount left and LVN I was verifying on the drug card. LVN B stated she was flagging a med for a resident and stated she needed to sign out for it but needed to verify the time she gave it. LVN B flagged the narcotic sheet in the binder. LVN B went behind the nurses station to check the time she administered the medication. At 6:22 a.m. The narcotic sheet remained flagged and LVN I was observed signing the narcotic book that the count was correct. LVN I confirmed that she had just signed the narcotic count was correct with the narcotic sheet still flagged and when asked if she normally signed the shift narcotic count sheet when it was not correct LVN B and LVN I both stated LVN B was currently fixing the issue. LVN B then stated it was given at 4:32 a.m. and signed the narcotic count sheet that she gave it at 4:30am and unflagged the narcotic sheet. (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 7/3/24 at 8:25 a.m., Resident #1 was self-propelling in his wheelchair to his room from the dining room. The resident was dressed in decorative pajama pants and a shirt with slippers. In the resident's room when asked about the previous incident with his missing pain pills the resident stated, you're here for something that happened 3 months ago? I explained it happened in June as reported to us and the resident stated, I don't know. I asked the resident about his missed doses of his pain medication and if he had been in pain when he missed the 4 doses of his pain medication and the resident stated of course I was in pain, that's why I take them when asked the resident for a number on the pain scale or what level of pain, mild, moderate, or severe the resident turned his head, sighed loudly and stated I don't know the resident then turned away from surveyor and would not speak after that. I excused myself and thanked the resident for his time. As I was leaving the room the resident stated, oh Lord why me. In a telephone interview on 7/3/24 at 10:34 a.m., LVN A stated she was the nurse for Resident #1 on the night of 6/12/24-6/13/24 and had discovered the missing narcotics for Resident #1 when she went to administer his 5:00 a.m. dose on 6/13/24 and she notified the DON immediately. LVN A stated the scheduled narcotics were on the CMA cart, when she got ready to do the med pass the sheets were there but the narcotic was not. LVN A stated the CMAs leave at 10pm and she keeps the keys for the CMA carts. LVN A stated she did not count with the CMA J prior to her leaving because she was tending to a Resident and CMA J had told her the count was correct and handed her the keys. LVN A stated she left for 10 minutes to get a soda but still had all the keys. LVN A stated she did leave the keys to the CMA carts in the drawer at the nursing station when she went to the bathroom because she had too many keys in her pockets to all the carts. Denied any knowledge of who took the medication. LVN A further stated she will lock the keys up in the medication room or in her cart if she doesn't have room in her pockets and will not leave them in drawers anymore and stated she knew she should have counted and not left the keys unattended. LVN A further stated she had no idea who could have taken Resident #1's narcotic medication and she was only gone for a few minutes and she does not know if the count was truly correct when she received the keys to the cart. In a telephone interview on 7/3/24 at 10:46 a.m., CMA J stated she was the off-going CMA and she had counted with the nurse when she came on duty on 6/12/24 and the count was correct for the start of her shift, CMA J stated LVN A was busy with a readmission, so she counted by herself when she left at 10:00 p.m. and it was the normal procedure and she handed the keys to LVN A and told her the count was correct and left. CMA J stated it was the normal routine for the CMAs to count by themselves but the narcotics were just put on the CMAs cart and Resident #1 had not complained of pain. CMA J denied taking any medications and stated she does not know what happened to them. CMA J further stated the nurse always counts with the CMA now and further stated she should have counted with another nurse if LVN A was busy. In an interview on 7/3/24 at 2:43 p.m., the DON stated the harm of the resident's pain medication missing could have been the possibility of pain. The DON confirmed Resident #1 missed 4 doses total of his norco scheduled pain medication. The DON further stated if Resident #1 had stated he had pain they could have contacted the physician for an alternate pain medication that does not require a triplicate prescription until his norco could be obtained from the pharmacy. The DON further stated he was assessed by the charge nurse and the DON and had stated he was not in pain. Review of the facility personnel records revealed background checks were completed as required for all staff on duty that evening (LVN A, CMA J, CNA F, and CNA G) (continued on next page)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy on reporting ANE revised December 2006 indicated . Misappropriation of resident property is defined as the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. Review of the facility policy on controlled substances revised December 2010 indicated . 5. Controlled substances must be stored in the medication room in a locked container, separate from containers for any non-controlled medications. This container must remain locked at all times, except when it is accessed to obtain medications for residents. 6. All keys to controlled substance containers shall be on a single key ring that is different from any other keys. 7. The Charge Nurse on duty will maintain the keys to controlled substance containers. The Director of Nursing Services will maintain a set of back-up keys for all drug storage areas including keys to controlled substance containers. 1. Nursing staff must count controlled drugs at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.