STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155066	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgewater Woods	1809 N Madison Ave Anderson, IN 46011

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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 - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect residents from misappropriation when residents' Institutional Special Needs Plan (ISNP) benefits were utilized by a staff member for purposes other than the individual resident's benefit for 3 of 3 residents reviewed for misappropriation of property (Resident D, Resident E, and Resident F). This deficient practice was corrected on 7/18/25, prior to the start of survey, and was therefore past noncompliance. Findings include: 1. Resident E's clinical record was reviewed on 8/28/25 at 11:21 a.m. Diagnoses included aphasia following cerebral infarction, cognitive communication deficit, and expressive language disorder. A quarterly Minimum Data Set (MDS) assessment, dated 6/4/25, indicated the resident was severely cognitively impaired. A progress note, dated 6/23/25 at 1:28 p.m., indicated the resident's representative was notified of a discrepancy with the resident's ISNP card and funds. The facility verified transactions and adjusted as needed for reconciliation. 2. Resident F's clinical record was reviewed on 8/28/25 at 1:39 p.m. Diagnoses included severe intellectual disabilities, unspecified dementia, cognitive communication deficit, other symptoms and signs involving cognitive functions and awareness, encephalopathy, and developmental disorder of speech and language. A quarterly MDS, dated [DATE], indicated the resident was severely cognitively impaired. A progress note, dated 6/23/25 at 1:30 p.m., indicated the resident's representative was notified of a discrepancy with the resident's ISNP card and funds. The facility verified transactions and adjusted as needed for reconciliation. 3. Resident D's clinical record was reviewed on 8/28/25 at 2:29 p.m. Diagnoses included metabolic encephalopathy. A quarterly MDS, dated [DATE], indicated the resident was moderately cognitively impaired. A progress note, dated 6/23/25 at 1:31 p.m., indicated the resident's guardian was notified of a discrepancy with the resident's ISNP card and funds. The facility verified transactions and adjusted as needed for reconciliation. During an interview, on 8/28/25 at 1:45 p.m., the Administrator indicated when the facility credit card was accessed to buy supplies for the activities department, it was noticed that several of the residents' ISNP accounts had zero balances, which was unusual. The Administrator was alerted and began an investigation. The Administrator discovered the Activities Director used multiple resident ISNP cards to purchase items for the activities program. She used the residents' individual ISNP benefits cards to purchase items for the facility. The Administrator indicated she believed the Activities Director did not think about what she was doing and had no intent to take anything from the residents' ISNP benefits. A review of the investigation file, provided by the Administrator on 8/28/25 at 2:26 p.m., indicated the following: According to the Timeline, the following occurred: On 6/17/25 at 1:30 p.m., the Business Office Manager informed the Administrator there was a concern with Resident D's ISNP benefits card. The transaction was identified that the Activities Director had gone to the grocery on that date to shop for the residents' needs. The Administrator spoke with the Activities Director about the expenses, asked her (Activities Director) to make a note of which resident to whom each item belonged and (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	where the item was stored. The Activities Director indicated she had put all the items on one transaction and must have utilized the wrong residents' benefits cards for the items. She did not know why she had not done individual transactions for each resident. The Activities Director indicated the residents' items were labeled, then later indicated the items still needed to be labeled for the residents. The Activities Director indicated the items had been purchased for Residents D, H, J, and K. A discrepancy was found in what was purchased on the receipt versus what the residents received. The Business Office Manager and the Administrator searched the activity room and storage room for the missing items. On 6/18/25, the Administrator completed an audit of the items at the facility from the grocery store receipt. A facility interview, on 6/18/25 with Activity Assistant 4, indicated she had assisted the Activity Director remove groceries from the Activity Director's car on 6/10/25. Too much was in the car to tell if any groceries were left in the car. The Activity Director brought in five bags of groceries that she said were for her (Activity Director) dinner. Popsicles were in one of the bags; the Activity Director had indicated the popsicles were on sale. She saw the Activity Director drink a bottle of Dr Pepper. The Activity Director delivered some items to the residents and told Activity Assistant 4 the remaining items went towards Bingo prizes and some baking activities. On 6/18/25, the Activity Director told Activity Assistant 4 she was suspended, gave Activity Assistant 4 a black marker, and asked her to label some items in the supply room. She reviewed the items on the list that were purchased. She did not recall seeing the missing items on the activity cart on the day she unloaded the groceries. She recognized the missing popsicles and bottle of Dr Pepper as items that were in the Activity Director's bags she took home. An undated facility interview with the Business Office Manager indicated the Activity Director had gone to the grocery store to get drinks and snacks for the residents. When the Activity Director returned, she indicated should had forgotten the receipt and would need to look it up on her phone. She told the Activity Director she needed the receipt to track purchases An undated facility interview with the Activity Director indicated, when asked what items she purchased for Resident E, she had bought items for his birthday party. Later, she indicated she had purchased items for Resident D, H, J, and K. She had not purchased any items for Resident E. She indicated she was not thinking, had purchased all the items on one transaction, and should have purchased the items on separate transactions for each resident. She must have accidentally used Resident E's ISNP benefits card. The cards had gotten out of order. She wrote down the names of the residents for whom each item was purchased. An undated facility interview with Resident J indicated she had received a six pack of Sprite and cheese puffs. She had not asked for any additional items, nor had she received any additional items. An undated facility interview with Resident H indicated he had received some sodas and crackers. He had not asked for any additional items, nor had he received any additional items. An undated facility interview with Resident K indicated she had received a six pack of Diet Coke and a bag of [NAME] cups. She had not asked for any additional items, nor had she received any additional items. An undated facility interview with Resident D indicated she had not asked for any items that week, nor had she received any items that week. An accounting of the items purchased on the receipt indicated a total of 85 items were purchased. Fifty-five items were located in the activity room or the storage room. Nine items were located in the residents' rooms, or the residents indicated the items had been received. Twenty-one items from the receipt were not located. On 6/18/25, the Activity Directory brought in three items that had not been previously located. Review of transactions (ISNP card charges) included in the facility investigation indicated: Resident E had $150.00 charged to card on 6/10/25 at 11:46 a.m. The starting balance on the card was $150.00 with a remaining balance of $0.00. Resident F had $150.00 charged to card on (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/10/25 at 11:47 a.m. The starting balance on the card was $150.00 with a remaining balance of $0.00. Resident D had $83.39 charged to card on 6/10/25 at 11:47 a.m. The starting balance on the card was $150.00 with a remaining balance of $66.61 Total charges at the grocery store on 6/10/25 were $383.39. ($150.00 + $150.00 + $83.29 = $383.39) During a phone interview, on 8/29/25 at 9:41 a.m., the Activity Director indicated, on the shopping trip on 6/10/25, she had everything rung up on one transaction. She had realized when the cashier rang them up, she should have separated the transactions. She didn't want it to be a hassle for the cashier. She used three different residents' ISNP cards to purchase the items. She took the items purchased back to the facility, gave them to the residents, put them in the refrigerator or storage for items that were a bulk purchase. She gave the Administrator the receipt. She marked who received the specific items and where the additional items were stored. The right people may not have received what items they were supposed to have received. The facility did not tell her what items were not found. She was fired for basically stealing food, though she did not steal anything. During an interview, on 8/29/25 at 11:46 a.m., Activity Assistant 4 indicated the former Activity Director went to the grocery store by herself. She did not know what items were purchased by the Activity Director. The items had not been labeled with residents' names and had been used for all the residents as far as she knew. The Activity Director had put names on the items in the refrigerator. She had not noticed the Activity Director using anything that belonged to the residents. The ISNP benefits card program was new to the facility. During an interview, on 8/29/25 at 2:08 p.m., the Administrator indicated when a resident was eligible for ISNP benefits, they were enrolled, and they received a grocery benefits card. The program was new to the facility. The benefits were to be used for items the residents wanted, or if the resident was cognitively unable to make decisions, then the resident's representative could assist with spending those benefits. The Business Office Manager kept the cards in her office for the residents' cards that were at the facility. The Activity Director had taken the facility credit card to get supplies for activities that day. Since she was buying items for the residents, she also took the residents' ISNP benefits cards to make purchases for those residents. After the incident with the cards, the ISNP benefit cards were stored in the business office safe. The cards must be signed out. An accounting for products purchased are required by the provision of a receipt. She in-serviced all the staff on the abuse policy as a whole, then focused on resident purchases and misappropriation of property. The staff were in-serviced on who to notify when a resident requests items. Social Services and the Business Office Manager was permitted to purchase items for the residents. The three residents affected were reimbursed. The investigation file, provided by the Administrator on 8/28/25 at 2:26 p.m., contained copies of checks for Resident D for $83.39 and Resident E for $150.00. A petty cash withdrawal receipt for Resident F for $150.00 was provided with an account statement that showed the resident's account had been credited with a cash payment of $150.00. An in-service sign in sheet for abuse/neglect/misappropriation of property for 6/19/25 was included. The in-service sheet contained 62 staff signatures. During an interview, on 8/29/25 at 2:35 p.m., the Administrator indicated she had discussed the incident at the facility Quality Assurance and Performance Improvement (QAPI) meeting. The facility had a QAPI meeting every other month A facility QAPI tool provided by the Administrator on 8/29/25 at 2:49 p.m., indicated under the Quality Assurance information for abuse prohibition measures - a misappropriation of property incident had been substantiated. No trends were identified. All staff were educated on abuse/misappropriation of property policy. The system for the ISNP benefit cares was discussed. Social Services and the Business Office Manager were permitted to use the benefit cards for the residents. The Business Office Manager tracked the receipts. The representative for the Provider (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Partners Health Plan (PPHP) will come to the facility monthly and check the members' accounts.The deficient practice was corrected on 7/18/25 after the facility implemented a systemic plan that included the education of staff regarding the facility's abuse and misappropriation of property policy, interviewed and/or assessed other residents for abuse, completed an Interdisciplinary Team (IDT) review of the incident, and planned for Quality Assurance activities to mitigate reoccurrence of the deficient practice. A current facility policy, last revised 6/2023 and provided by the DON on 8/28/25 at 4:10 p.m., titled Abuse Prohibition, Reporting, and Investigation, indicated the following: It is the policy of American Senior Communities to provide each resident with an environment that is free from abuse, neglect, misappropriation of resident property, and exploitation.Misappropriation of Resident Funds or Property - Deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's property or money without the resident's consent. This citation relates to Intake 1630260. 3.1-28(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to ensure a resident's catheter was anchored according to the physician's orders for 1 of 3 residents reviewed for catheters. (Resident C) Findings include: Resident C's closed clinical record was reviewed on 8/27/25 at 3:36 p.m. Diagnoses included infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter, other obstructive and reflux uropathy, urinary tract infection, and benign prostatic hyperplasia with lower urinary tract symptoms. Physician orders included cefpodoxime (antibiotic) 200 milligrams (mg) every 12 hours for urinary tract infection (7/25/25 - 7/27/25), levofloxacin (antibiotic) 500 mg daily (7/30/25 - 8/5/25), trospium (for overactive bladder) 20 mg twice a day (7/24/25), Foley catheter: 16 French 5-10 milliliter (mL) bulb (7/25/24 - 7/30/25), Foley catheter: 18 French 10 mL bulb (7/30/25), If resident does not void in six hours anchor foley catheter (7/29/25 - 7/30/25), and May use 18 French catheter to re-anchor until a 16 French 10 mL is available (7/29/25). An admission Minimum Data Set (MDS) assessment, dated 7/30/25, indicated the resident was cognitively intact. He required substantial/maximal staff assistance with toileting and showering hygiene. He required partial/moderate staff assistance with transferring to the toilet and the tub. He had an indwelling catheter and was frequently incontinent of bowels. His primary medical condition was infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter. A care plan for urinary tract infection (UTI) (created and last reviewed/revised 7/24/25) had a goal that the resident will be free from symptoms of UTI. Approaches included administering antibiotic as ordered, assisting with incontinence care, and observing for continued or worsening symptoms of UTI such as acute dysuria (painful urination), fever, costovertebral angle pain or tenderness, suprapubic pain, hematuria, worsening incontinence, urgency, and frequency. A care plan for UTI prophylaxis related to foley removal (created and last reviewed/revised 7/30/25) had a goal that the resident will be free from symptoms of UTI. Approaches included administering antibiotic as ordered, assisting with incontinence care, and observing for continued or worsening symptoms of UTI such as acute dysuria (painful urination), fever, costovertebral angle pain or tenderness, suprapubic pain, hematuria, worsening incontinence, urgency, and frequency. A care plan for the resident required an indwelling catheter related to other obstructive and reflux uropathy (created and last reviewed/revised 8/5/25) had a goal that resident will have catheter care managed appropriately as evidenced by; Not exhibiting signs of urinary tract infection or urethral trauma. Approaches included avoid obstructions in the drainage, change catheter per physician order, provide assistance for catheter care, and use 18 French 10 mL foley catheter per physician order. A urology procedure visit report, dated 7/29/25, signed by the urologist on 7/29/25 at 11:26 a.m., indicated the resident's catheter was removed. A nursing progress note, dated 7/29/25 at 12:42 p.m., indicated the resident had been seen by the urologist that morning and returned with new orders. The staff nurse had the packet from the urologist. Family was aware of the appointment and the new orders sent back with the resident. A nursing progress note, dated 7/29/25 at 2:07 p.m., indicated the resident was seen by the urologist and returned with new orders. A nursing progress note, dated 7/29/25 at 5:06 p.m., indicated the resident had not voided. The resident requested the catheter to be re-anchored after supper. A grievance report, dated 7/29/25 at 8:25 p.m., indicated the resident representative emailed the Administrator regarding concern that the resident's catheter had not been re-anchored. The Administrator called the charge nurse at 8:32 p.m. on 7/29/25. The charge nurse indicated the resident had refused to have the catheter re-anchored earlier and wanted to wait until after dinner. The ordered catheter size was not available, and she had to wait to get an order (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the nurse practitioner. The new order was received, and the catheter was placed at approximately 8:45 p.m. A nursing progress note, recorded on 7/30/25 at 3:04 a.m., dated 7/29/25 at 8:44 p.m., indicated the nurse went to see if the resident was ready to have his catheter anchored. He did not have any urinary output. An order for a 16 French 10 mL bulb catheter was ordered which was not available. The nurse practitioner was notified and gave an order for the resident to use an 18 French 10 mL bulb coude (type of catheter). The catheter was anchored with an immediate return of urine. The resident received an as needed pain medication at 8:12 p.m. prior to catheterization, had a fentanyl patch in place, and received routine acetaminophen to manage pain. The resident voiced no concerns. The physician's report, signed at 11:26 a.m., indicated the catheter was removed. The late entry nursing progress note, on 7/30/25 at 3:04 a.m., and the grievance report, on 7/29/25 at 8:25 a.m., indicated the catheter was re-anchored at approximately 8:45 a.m. The physician's order indicated to anchor a foley catheter if the resident did not void in six hours. The time between urinary catheter removal and re-anchoring of the urinary catheter was over nine hours. During an interview, on 8/29/25 at 11:05 a.m., RN 5 indicated when a urinary catheter was removed, the resident should go no longer than eight hours to void. She would follow the physician's orders on what actions should be taken if the resident did not void. If the correct size of the catheter was not available, she would use a smaller size catheter and get an order from the physician. Catheter supplies were kept in the large storeroom or sometimes in the tiny storeroom where a few supplies are also stored. The Scheduler was responsible for ordering and ensuring medical supplies were available. During an interview, on 8/29/25 at 11:51 a.m., the Unit Manager indicated when a resident had a foley catheter removed she would follow the physician's orders. She would expect the resident would need to have a catheter anchored in eight hours if the resident had not voided. During an interview, on 8/29/25 at 12:00 p.m., the Scheduler indicated she tried to keep one of every size of catheter in stock at the facility. They discussed in morning meeting when a new admission came in what needs the resident had such as sizes of catheters, feeding tubes, and tracheostomy supplies. During an interview, on 8/29/25 at 1:46 p.m., the DON indicated when a catheter was removed, per standard practice, the resident would need to be catheterized in eight hours or per the physician's orders if the resident did not void. The resident had declined the catheter earlier, and the nurse had to get a new order because she did not have the correct catheter size. She was uncertain if the nurse could not find the correct size catheter or if it was not available. During an interview, on 8/29/25 at 2:43 p.m., the DON indicated she had procedure steps for catheter care and emptying a urinary drainage bag. The facility did not have any additional policies for urinary catheters. According to the National Library of Medicine website from the National Institutes of Health (NIH) accessed on 8/29/25 at https://www.ncbi.nlm.nih.gov/books/NBK596722/, .When removing an indwelling urinary catheter, it is considered a standard of practice to document the time and track the time of the first void. This information is also communicated during handoff reports. If the patient is unable to void within 4-6 hours and/or complains of bladder fullness, the nurse determines if incomplete bladder emptying is occurring according to agency policy. The ANA [American Nurses Association] has made the following recommendations to assess for incomplete bladder emptying: The patient should be prompted to urinate. If urination volume is less than 180 mL, the nurse should perform a bladder scan to determine the post-void residual. A bladder scan is a bedside test performed by nurses that uses ultrasonic waves to determine the amount of fluid in the bladder. If a bladder scanner is not available, a straight urinary catheterization is performed. This citation relates to Intake 2582493. 3.1-41(a)(2)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide physician ordered pain medication in a timely manner for 1 of 3 residents reviewed for admission. (Resident C) Finding includes:Resident C's closed clinical record was reviewed on 8/27/25 at 3:26 p.m. Diagnoses included rheumatoid arthritis, polyneuropathy, post-laminectomy syndrome (syndrome after spinal surgery characterized by persistent or worsening pain, numbness, tingling, and weakness in the legs or back), and chronic pain due to trauma. Physician orders included fentanyl (opiate pain medication) patch 75 mcg (micrograms)/hour every other day (7/25/25), hydromorphone (opiate pain medication) 4 milligrams (mg) every four hours as needed (PRN) for moderate pain (7/24/25), ibuprofen (anti-inflammatory medication) 600 mg three times a day (7/25/25), acetaminophen (Tylenol) 650 mg every four hours PRN (as needed) for mild pain (7/24/25), and acetaminophen every four hours (7/24/25). An admission Minimum Data Set (MDS) assessment, dated 7/30/25, indicated the resident was cognitively intact. He received a scheduled pain medication and a PRN pain medication. He complained of frequent moderate pain that frequently affected his therapy, sleep, and day-to-day activities. A care plan for pain (created and last reviewed/revised on 7/29/25) had a goal that the resident will be free from adverse effects of pain. The approaches included administering medications as ordered, documenting effectiveness of medications, and notifying the physician if pain is unrelieved and/or worsening. A hospital discharge summary which included medications administered, dated 7/23/25, indicated the resident had last received a PRN hydromorphone on 7/23/25 at 12:05 p.m. The resident face sheet indicated he was admitted on [DATE] at 6:57 p.m. A nursing progress note, dated 7/23/25 at 6:57 p.m., edited by the nurse on 7/24/25 at 10:10 a.m. because more data was available, (recorded on 7/24/25 at 10:08 a.m.), indicated the resident arrived at the facility. The resident complained of pain and discomfort that shift and had an order for hydromorphone and a fentanyl patch. Placement of the patch on the resident's left arm was verified by two nurses. The resident complained of pain, but the medications had not yet been delivered. The nurse notified the pharmacy and confirmed orders. The pharmacy indicated the orders were sent out and should be there soon. Resident was made aware. Acetaminophen was offered and administered. The resident was told when the pharmacy arrived with the medications, the nurse would check on the resident to see if he needed stronger pain medications. The resident voiced understanding and voiced no other concerns. A nursing progress note, dated 7/24/25 at 12:50 a.m. (recorded as late entry on 7/25/25 at 12:14 p.m.), indicated the pharmacy delivered stat medications at that time. A nursing progress note, dated 7/24/25 at 2:30 a.m. (recorded as late entry on 7/25/25 at 12:21 p.m.), indicated the resident pressed his call light at that time and a PRN medication was administered with no concerns voiced. The nurse told the resident when the medication arrived the staff had checked on the resident, and the resident appeared to be resting peacefully. She waited until he woke up and pressed the call light for the PRN pain medication. The resident replied he had taken a little nap. A nursing progress note, dated 7/24/25 at 6:57 a.m., indicated the resident arrived at the facility. The resident complained of pain and discomfort that shift and had an order for hydromorphone and a fentanyl patch. Placement of the patch on the resident's left arm was verified by two nurses. The residents complained of pain, but the medications had not yet been delivered. The nurse notified the pharmacy and confirmed orders. The pharmacy indicated the orders were sent out and should be there soon. The resident was made aware. Acetaminophen was offered and administered. The resident was told when the pharmacy arrived with the medications, the nurse would check on the resident to see if he needed stronger pain medications. The resident voiced understanding and voiced no other concerns. The medication administration record for 7/2025 (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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was reviewed. The PRN (as needed) medications given as mentioned in the 7/23/25 note on the resident's admittance were not documented. The first documented given dose of PRN hydromorphone indicated the resident took the medication at 6:53 a.m. with a pain rating of 8 on a 1 to 10 scale. A narcotic count sheet indicated the hydromorphone was received on 7/24/25 at 12:50 a.m. and given at 2:30 a.m. The resident routinely took between four and six PRN hydromorphone daily to manage pain from 7/24/25 through 7/29/25. During a phone interview, on 8/28/25 at 11:09 AM, Resident C's representative indicated the resident had called the resident representative on the night he was admitted . The resident indicated he was in pain. He told the resident representative the facility did not have his medications, and no one would help him. He asked the resident representative to help him and bring his medications from home. During an interview, on 8/29/25 at 11:19 a.m., LPN 7 indicated when a resident was admitted , the orders were transcribed, and everything not in the emergency drug kit was ordered stat (immediately). She expected to get all medications within four hours. If the resident was in pain and the ordered pain medication was not available, she would call the physician to see if could get something else until the ordered medication was available. During an interview, on 8/29/25 at 11:28 a.m., RN 5 indicated for a newly admitted resident, she ordered from the pharmacy the medications that were not in the emergency drug kit. The medications were supposed to arrive within four hours after ordering. If the resident was requesting a pain medication and it was not in the emergency drug kit, then she would call the physician and get a temporary order for a different pain medication until the original ordered medication was available. During an interview, on 8/29/25 at 11:51 a.m., the Unit Manager indicated for a newly admitted resident, she utilized the emergency drug kit and then called the pharmacy for everything else to be sent stat. When the medications were ordered stat, they came within four hours. If the ordered pain medication for the resident was requested and not available, she would call the nurse practitioner and get an alternative medication to give that was available in the emergency drug kit. During an interview, on 8/29/25 at 1:56 p.m., the DON indicated when the facility received a new admission, anything that was in the emergency drug kit would not be sent out stat to the facility. Anything not in the emergency drug kit would be sent by the next morning. She did not believe the medications were received the night the resident was admitted . If the resident needed a pain medication, she would call the pharmacy to have the pain medication sent stat. If the resident had another pain medication would try to use that first to see if the other pain medication would help. She indicated if the resident were on hydromorphone, she did not expect acetaminophen would be effective to manage the pain. The physician should be notified to see what should be done. A current facility policy, last revised 7/2024, provided by the DON on 8/29/25 at 12:17 p.m., titled Pain Management Policy, indicated the following: .It is the policy of American Senior Communities to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial wellbeing, including pain management.Residents are assessed for pain upon admission.Interviewable Resident - Pain medications will be prescribed and given based upon the intensity of the pain as follows using the verbal descriptive, numerical scale (1-10) or Wong-Baker FACES Scale.SEVERE = (6-8).Documentation of administration of ordered PRN pain medication will be documented on the Electronic Medication Administration Record (EMAR). This citation relates to Intake 2582493. 3.1-37(a)