

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2025
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  18648 Hillcrest Rd Dallas, TX 75252	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interviews and record review, the facility failed to provide pharmaceutical services including procedures that assured the accurate acquiring, receiving, dispensing, and administering of all routine and emergency drugs and biologicals for 3 residents (Resident #1, Resident #2, and Resident #3) of 5 residents reviewed for pharmacy services.</p> <p>1.</p> <p>The facility failed to ensure Resident #1's Hydrocodone-Acetaminophen were ordered and administered according to physician's orders, causing the resident to miss 3 doses in May 2025.</p> <p>2.</p> <p>The facility failed to ensure Resident #2's Hydrocodone-Acetaminophen were ordered and administered according to physician's orders, causing the resident to miss 2 doses in April 2025.</p> <p>3.</p> <p>The facility failed to ensure Resident #3's Oxycodone HCL were ordered and administered according to physician's orders, causing the resident to miss 2 doses in May 2025.</p> <p>These failures could place residents at risk for not receiving therapeutic dosages of their medications as ordered by the physician and a potential for decreased health status and decreased quality of life.</p> <p>Findings included:</p> <p>1.</p> <p>Record review of Resident #1's face sheet, dated 6/03/25, reflected the resident was a [AGE] year-old female who initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident #1 had diagnoses that included: fibromyalgia (disease that causes widespread pain and fatigue in body), and chronic pain syndrome.</p> <p>(continued on next page)</p>

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:  676315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2025
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  18648 Hillcrest Rd Dallas, TX 75252	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #1's Quarterly MDS assessment, dated 4/11/25, reflected her BIMS score was 15, which indicated the resident was cognitively intact. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #1 required partial to moderate assistance with most self-care ADLs and was independent with all mobility ADLs. Further review of this document under Section J-Health Conditions, reflected the resident received a scheduled pain medication regimen with pain being present rarely and mildly.</p> <p>Record review of Resident #1's care plan, dated 4/21/25, reflected the resident was on pain medication therapy r/t dx of pain. Interventions included: administering medication as order, asking physician to review medication if side effects persist, monitoring respirations, monitoring for altered mental status and adverse reactions, monitoring for increased risk for falls, and reviewing for pain medication efficacy (desired results). Further review of this document reflected Resident #1 required pain management (hydrocodone) d/t pain in right and left shoulder. Interventions included: honoring resident's wishes to d/c Lidocaine patches, administering analgesia (pain reliever), as ordered, anticipating the resident's need for pain relief and responding immediately, evaluating the effectiveness of pain interventions, and monitoring and documenting any side effects of pain medication.</p> <p>Review of Resident #1's active order summary, dated 6/03/25, reflected the resident was ordered the following medications for pain:</p> <ul style="list-style-type: none"> <li>-Biofreeze External Gel 4%-apply to left shoulder/neck topically every 12 hours as needed for acute pain. Start date: 4/15/24.</li> <li>-Hydrocodone-Acetaminophen oral tablet 5-325 mg-give 1 tablet by mouth five times a day (6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM, 10:00 PM) related to fibromyalgia; pain in right shoulder; pain in left shoulder. Start date: 12/19/24.</li> <li>-Methocarbamol oral tablet 500 mg-give 1 tablet by mouth three times a day (7:00 AM, 1:00 PM, and 7:00 PM) for muscle spasms. Start date: 1/05/23.</li> <li>-Methocarbamol oral tablet 500 mg-give 1 tablet by mouth every 8 hours as needed. Start date: 1/05/23.</li> </ul> <p>Record review of Resident #1's Medication Administration Record for May 2025, reflected the following:</p> <ul style="list-style-type: none"> <li>-Hydrocodone-Acetaminophen oral tablet 5-325 mg was not administered on 5/31/25 at 10:00 AM, 2:00 PM, or 6:00 PM.</li> </ul> <p>Record review of Resident #1's-controlled drug administration record, dated 5/31/25, reflected the following:</p> <ul style="list-style-type: none"> <li>-Hydrocodone APAP 5-325 MG- 120 tablets were received at the facility on 5/31/25 (time not specified) and the first dose was signed out on 5/31/25 at 10:00 PM.</li> </ul> <p>Record review of Resident #1's progress notes, dated 5/31/25 at 1:42 PM by the ADON, reflected the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2025
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  18648 Hillcrest Rd Dallas, TX 75252	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Late Entry- [ADON] was notified by nurse that norco was unavailable. [ADON] notified [Pain Management NP] of situation N/O to hold norco give Tylenol 500mg for pain until norco arrives.</p> <p>In an observation and interview on 6/03/25 at 10:00 AM, Resident #1 was lying in bed in her room with no signs of distress or pain. Resident #1 stated she felt good and denied currently being in pain. She stated having no concerns at the facility except for this past weekend when they ran out of her pain medication (Hydrocodone). Resident #1 stated she could not recall the exact day, but she remembered receiving the first morning dose and the nurse telling her the MD was being called because they did not have any medication for her next dose. Resident #1 stated she received Tylenol instead of Hydrocodone for one of her doses but could not recall which dose. She stated the Tylenol helped some and she slept most of the day so she could not remember being in severe pain. Resident #1 stated by evening she was able to receive her Hydrocodone.</p> <p>In an interview on 6/03/25 at 12:46 PM, the ADON stated LVN C notified her that Resident #1 was out of her Hydrocodone and the Pain Management NP had been notified. The ADON stated LVN C was unable to get the medication from the emergency kit because the order at the pharmacy needed to be updated and they would not allow the Hydrocodone to be dispensed. The ADON stated the Pain Management NP gave a new order for Tylenol 3 while she worked on submitting a new order for the Hydrocodone, which arrived at the facility the same day. The ADON stated the facility had protocols in place to prevent the residents from running out of medications . She stated the nurses were able to get medication from the emergency kit, have an emergency prescription sent to a local pharmacy if there was an issue with their contracted pharmacy, or call the MD for an alternative order.</p> <p>In an interview on 6/03/25 at 2:27 PM, the Administrator stated she worked at the facility since 2/2025. The Administrator stated she was aware of the issue the facility was having with ensuring that medications were re-ordered on time. She stated the facility was going through a turn-over with new management and she was trying to get everyone trained. She stated she was notified about the recent incident when Resident #1 ran out of her Hydrocodone. She stated the nurses used a texting system to communicate with management, and LVN C texted on 5/31/15 at approximately 11:00 AM that Resident #1 did not have any Hydrocodone and she was unable to get a dose from the emergency kit because there was not an updated order on file. The Administrator stated the nurse notified the NP was able to get an order to administer Tylenol 3.</p> <p>An attempted interview on 6/03/25 at 2:45 PM with LVN C, who worked with Resident #1 when she ran out of her narcotic pain medication, was unsuccessful due to no response to call.</p> <p>2.</p> <p>Record review of Resident #2's face sheet, dated 6/03/25, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #2 had diagnosis of fractures of lower end of left radius.</p> <p>Record review of Resident #2's admission MDS assessment, dated 3/18/25, reflected her BIMS score was 15, which indicated the resident was cognitively intact. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #2 required moderate assistance with most self-care ADLs and moderate assistance with most mobility ADLs. Further review of this document under Section J-Health Conditions, reflected the resident did not receive a scheduled pain medication regimen, but received PRN pain medications, with pain being present frequently with pain at a 7 on a scale from 0-10.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2025
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  18648 Hillcrest Rd Dallas, TX 75252	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Record review of Resident #2's care plan, dated 4/11/25, reflected the resident required pain management r/t femur and radius fracture. Interventions included: administering analgesia (pain reliever), monitoring and documenting for side effects of pain medication, and monitoring, documenting, and reporting the resident's complaints of pain and requests for pain treatment.</p> <p>Review of Resident #2's active order summary, dated 6/03/25, reflected the resident was ordered the following medications for pain:</p> <ul style="list-style-type: none"> <li>- Methocarbamol oral tablet 500 mg-give 1 tablet by mouth four times a day (7:00 AM, 11:00 AM, 3:00 PM, and 7:00 PM) for pain. Start date: 3/14/25.</li> <li>-Oxycodone HCL oral tablet 5 mg-give 1 tablet by mouth every 4 hours (12:00 AM, 4:00 AM, 8:00 AM. 12:00 PM, 4:00 PM, and 8:00 PM) for pain. Start date: 4/15/25.</li> </ul> <p>Record review of Resident #2's Medication Administration Record for May 2025, reflected the following:</p> <ul style="list-style-type: none"> <li>-Oxycodone HCL oral tablet 5 mg-not administered on 5/27/25 at 12:00 AM or 4:00 AM. Resident #2 was away from the facility for doses at 8:00 AM, 12:00 PM, and 4:00 PM. Documented as administered at 8:00 PM on 5/27/25.</li> <li>-Pain assessment- pain level documented as 0 for day, 2 for evening, and 2 for night on 5/27/25.</li> </ul> <p>Record review of Resident #2's progress notes, dated 5/27/25 at 9:06 AM by LVN B, reflected the following:</p> <p>[LVN B] called [pharmacy] about oxycodone order reported would be on evening delivery [Resident #2] notified of above information.</p> <p>Record review of Resident #2's-controlled drug administration record, dated 5/27/25, reflected the following:</p> <ul style="list-style-type: none"> <li>- Oxycodone HCL oral tablet 5 mg - 120 tablets were received at the facility on 5/27/25 (time not specified) and the first dose was signed out on 5/27/25 at 8:00 PM.</li> </ul> <p>In an observation and interview on 6/03/25 at 10:13 AM, Resident #2 was lying in bed watching television. She did not appear to be in discomfort or pain and had her left arm propped on a pillow. Resident #2 denied being in pain and stated the staff were taking good care of her. Resident #2 stated the facility was a nice place. Resident #2 stated she did not want to get anyone in trouble but there was a time she was unable to get her pain medication (Oxycodone). Resident #2 stated she heard the nurse who forgot to reorder her pain medication had been terminated for making the same mistake with other residents, and there had been no issues since then. Resident #2 stated the day the facility was out of her Oxycodone, they gave her another pain medication, but she could not remember what it was, but it helped some. She stated she was still in a little pain, but it was tolerable. Resident #2 stated her Oxycodone was available later that day.</p> <p>An attempted interview on 6/03/25 at 4:28 PM with LVN B, who worked with Resident #2 when she ran out of her narcotic pain medication, was unsuccessful due to no response to call.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2025
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  18648 Hillcrest Rd Dallas, TX 75252	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3.</p> <p>Record review of Resident #3's face sheet, dated 6/03/25, reflected the resident was a [AGE] year-old female who admitted to the facility on [DATE]. Resident #2 had diagnoses that included: depression (mood disorder), multiple pressure ulcers/open wounds, chronic pain, hypotension (low blood pressure), complete traumatic amputation at level between left hip and knee and acquired absence of right leg above knee.</p> <p>Record review of Resident #3's Quarterly MDS assessment, dated 4/13/25, reflected her BIMS score was 15, which indicated the resident was cognitively intact. The MDS Assessment under Section GG-Functional Abilities, reflected Resident #3 required moderate to maximal assistance with most self-care ADLs and maximal assistance with most mobility ADLs. Further review of this document under Section J-Health Conditions, reflected the resident received a scheduled pain medication regimen with pain being present frequently with pain at a 7 on a scale from 0-10.</p> <p>Record review of Resident #3's care plan, dated 5/15/25, reflected the resident had neuropathic pain. Interventions included: anticipating the resident's need for pain relief and responding immediately, monitoring and documenting side effects of pain medication, notifying the physician if interventions are unsuccessful or change in complaint of pain, observing and reporting any changes in usual routines.</p> <p>Review of Resident #3's active order summary, dated 6/03/25, reflected the resident was ordered the following medications for pain:</p> <p>- Hydrocodone-Acetaminophen oral tablet 10-325 mg-give 1 tablet by mouth every 4 hours (12:00 AM, 4:00 AM, 8:00 AM, 12:00 PM, 4:00 PM, 8:00 PM) for pain related to neuralgia (nerve pain) and neuritis (inflammation of nerves). Start date: 3/12/25.</p> <p>Record review of Resident #3's Medication Administration Record for April 2025, reflected the following:</p> <p>-Hydrocodone-Acetaminophen oral tablet 10-325 mg- not administered on 4/13/25 at 12:00 AM or 4:00 AM.</p> <p>-No pain assessment monitoring scale (outside of pain scale for routine Hydrocodone-Acetaminophen administration)</p> <p>Record review of Resident #3's-controlled drug administration record, dated 4/13/25, reflected the following:</p> <p>-Hydrocodone APAP 10-325 MG- 120 tablets were received at the facility on 4/13/25 (time not specified) and the first dose was signed out on 4/14/25 at 12:00 AM.</p> <p>Record Review of emergency kit record for Resident #3, dated 4/13/25, reflected the following was dispensed:</p> <p>- Hydrocodone-Acetaminophen oral tablet 10-325 mg- dispensed on 4/13/25 at 9:59 AM , 1:27 PM, and 4:10 PM.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2025
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  18648 Hillcrest Rd Dallas, TX 75252	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an observation and interview on 6/03/25 at 10:18 AM, Resident #3 did not appear to be in discomfort or pain. She stated she currently felt fine and had received all meds as ordered so far today. Resident #3 stated the facility had the potential to be great, but they kept losing their good nurses and were hiring people who were less experienced and would work for less money. Resident #3 stated because of this, the nurses were not always refilling the medication on time and would have to scramble to figure something out. Resident #3 stated the facility ran out of her Hydrocodone a few months ago. She stated they gave her Tylenol and some other alternative pain medication until they could get Hydrocodone reordered. She could not recall how much pain she was in but stated she was sure the Tylenol did something for the pain. She stated she was able to get her Hydrocodone at some point during that day. Resident #3 stated that was the only time she could recall not having her Hydrocodone available.</p> <p>In an interview on 6/03/25 at 4:37 PM, LVN D stated she worked at the facility since 4/05/25. She stated she worked with Resident #3 and remembered there being an issue with her insurance paying for her Hydrocodone, which was what delayed the order being refilled. LVN D stated she worked with Resident #3 on 4/13/25 when the facility ran out of her Hydrocodone. LVN D stated she called the pharmacy and NP and was able to get the Hydrocodone refilled. LVN D stated the medication came the same day and she was at the facility when it arrived. LVN D stated the nurses were responsible for administering and reordering all narcotic medications. She stated they had to reorder the medications when it got down to the blue area on the medication card that was marked for Reorder, and not wait until the last pill. LVN D stated any issues with the pharmacy or getting medications from the emergency kit would be immediately reported to the DON and MD.</p> <p>In an interview on 6/03/25 at 1:03 PM, the DON stated she started working at the facility on 5/14/25, so had only been there for about 3 weeks. The DON stated it was the nurses' responsibility to notify the MD and reorder narcotics as needed. The DON stated the nurses did a narcotic count with the oncoming nurse during shift change and knew when the medications were getting low and needed to be reordered. The DON stated the previous DON had a system in place for the nurses to know when to reorder the meds. She stated she was not sure how many pills had to be remaining before they could reorder. The DON stated she was still learning and working on getting her own system in place. The DON stated the facility had a Pyxis cabinet available at the facility to dispense emergency medications when needed. She stated the pharmacy did an electronic count to ensure that cabinet was always stocked with medication, and the ADON and DON were responsible for doing a manual check at least weekly.</p> <p>In an interview on 6/03/25 at 1:21 PM, the Pharmacy Representative, stated the pharmacy received an electronic report from the Pyxis of the available inventory and automatically sent a signal to the pharmacy when a medication was getting low and needed to be refilled. The Pharmacy Representative stated when a medication needed to be refilled, the pharmacy would send someone over to exchange the medication drawer to refill with a nurse at the facility. She stated if there was a discrepancy with a resident's medication for whatever reason and the nurse needed to get an emergency dose, they could notify the pharmacy to get a one-time access code to go into the Pyxis and get the medication. She stated this service was always available to the facility, even on the weekends. The Pharmacy Representative stated the only way the pharmacy would not allow a nurse to get a medication from the Pyxis was if there was not an active order on file for the resident.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  676315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/03/2025
NAME OF PROVIDER OR SUPPLIER  The Hillcrest of North Dallas		STREET ADDRESS, CITY, STATE, ZIP CODE  18648 Hillcrest Rd Dallas, TX 75252	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>In an interview on 6/03/25 at 2:45 PM, the VP of Clinical Services stated the facility was going through a transition with new management and she was there to help with clinical issues. The VP of Clinical Services stated the previous DON left unexpectedly and the facility was without a DON for a few weeks, and that was when a lot of the issues with reordering medications came about. The VP of Clinical Services stated there were insurance issues with some of the medications and the pharmacy was sending the alerts to the previous DON's email, which the facility was not aware. She stated this caused a delay in getting some of the orders refilled on time. The VP of Clinical Services stated they have added more contacts for the pharmacy to resolve this issue. She stated she was also in-servicing the nurses on medication administration, documentation, and reordering medications in a timely manner.</p> <p>In an interview on 6/03/25 at 4:12 PM, the Pain Management NP stated her expectation was for the nurses to notify her 2-3 days ahead of time when an order needed a refill. She stated if the nurses did not notify her in time or if there were any other issues, they could either call the pharmacy and get a code to get the medication from the emergency kit or call her for an alternative. The Pain Management NP stated residents are sometimes on other medications for pain that would be enough to alleviate their pain until the narcotic was available. She stated Methocarbamol was used as a muscle relaxer and pain medication and was a medication that she would order as an alternative to be used for pain. She stated Resident #1 and Resident #2 were both ordered Methocarbamol to help with their pain. The Pain Management NP stated Gabapentin was another medication that was for pain, especially nerve pain, that would help alleviate pain until a narcotic was available. She stated Resident #3's pain was mostly nerve pain, and the Gabapentin would have helped alleviate her pain. The Pain Management NP stated the risk of residents not having narcotic pain medication available as ordered could be increased pain and withdrawal symptoms.</p> <p>Review of the facility policy titled Medication-Administration, undated, reflected in part the following:</p> <p>Purpose: To provide practice standards for safe administration of medications for residents in the Facility.</p> <p>Policy: I.</p> <p>Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner, or as consistent with state law.</p> <p>A policy regarding reordering narcotic medications was requested from the Administrator on 6/03/25 and was not received by exit.</p>		