STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155488		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 01/28/2025				
NAME OF PROVIDER OR SUPPLIER ROLLING HILLS HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 3625 ST JOSEPH RD NEW ALBANY, IN 47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
F 0000								
Bldg. 00	This visit was for th IN00450462.	ne Investigation of Complaint	F 0000					
		njuction with the Post Survey int IN00448446 completed on						
	_	0462 - Federal/State deficiencies tions are cited at F761 and						
	Complaint IN00448	3446 - Not corrected.						
	An unrelated deficie	ency cited.						
	Survey dates: Janua	ary 25, 27 and 28, 2025						
	Facility number: 00 Provider number: 1 AIM number: 1002	55488						
	Census Bed Type: SNF/NF: 92 Total: 92							
	Census Payor Type: Medicare: 3 Medicaid: 34 Other: 55 Total: 92							
	These deficiencies raccordance with 410	reflect State findings cited in 0 IAC 16.2-3.1.						
	Quality review com	pleted on January 30, 2025.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Cheryl Fagundo RNDON 02/12/2025

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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.

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STATEMENT OF DEFICIENCIES 2		X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	LETED	
		155488	B. WI	NG		01/28	/2025	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			ST JOSEPH RD			
ROLLING	G HILLS HEALTHC	ARE CENTER		NEW A	ALBANY, IN 47150			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE	
F 0690	483.25(e)(1)-(3)							
SS=D	Bowel/Bladder Inc	continence, Catheter, UTI						
Bldg. 00	 D 1 1 4'		F 04	500			00/10/2025	
		on, interview and record	F 06	90	Preparation and execution of	ihis	02/18/2025	
	1	failed to ensure Indwelling			plan of correction does not			
		s were implemented for 1 of 3			constitute admission or agree			
	residents reviewed for Indwelling catheters.				by this provider of the truth of			
	(Resident M)				facts alleged or conclusions so	Эĭ		
	F' 1' ' 1 1				forth in the Statement of			
	Findings include:				Deficiencies. The plan of			
	Om 1/20/25 at 11.20	9 a.m., the resident was			correction is prepared and			
					executed solely because it is			
	observed sitting in a chair in her room with an Indwelling catheter in place.				required by the provisions of federal and state law.			
	indweining cameter	in place.			The facility cordially requests			
	The clinical record	for Resident M was reviewed			paper compliance regarding			
		a.m. The resident's diagnosis			alleged deficient practices.			
		not limited to, stage 4 sacral			Due to confidentiality	v of		
		and that extends through all			the complaint survey Resident			
		reaching the underlying muscle,			can't be identified.	LIVI		
	tendon or bone).	caeming the underlying masele,			2) All residents with a			
	tendon or cone).				catheter are at risk to be affect	ted		
	The care plan, date	d 1/13/25, indicated the			All residents with a catheter to			
	_	welling catheter and to provide			reviewed to assure residents h			
	catheter care every				catheter care orders in place.			
					discrepancies will be addresse	-		
	The clinical record	lacked documentation of any			immediately with resident			
		care for Resident M.			assessments and NP/MD			
					notifications.			
	During an interview	w on 1/28/25 at 9:55 a.m., Staff			3) DON/Designee will			
	_	ed Indwelling catheter care			educate the licensed nurses o	n		
	orders should be in	nplemented upon admission.			companies Catheter Care Pol	icy,		
					emphasizing on assuring cath	-		
	On 1/28/25 at 2:44	p.m., the Regional Director of			care orders are in place for			
	Clinical Operations	s provided a current, undated			residents with catheters.			
	copy of the docume	ent titled "Catheter Care". It			4) DON/Designee will a	audit		
	included, but was n	not limited to, "PolicyIt is the			all residents with a catheter			
	policy of this facili	ty to provide resident centered			weekly for 3 months to validat	e		
		e is performed twice daily on			residents with a catheter have			
1		indwelling catheters, for as			catheter care orders in place		1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155488 B. WING 01/28/2025 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 3625 ST JOSEPH RD ROLLING HILLS HEALTHCARE CENTER NEW ALBANY. IN 47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE long as the catheter is in place...." DON/Designee will report on audits monthly to the 3.1-41(a)(2)interdisciplinary team for 3 months during the QAPI Meeting. The IDT will determine if the audits are necessary to continue after 3 months with 100% compliance F 0761 483.45(g)(h)(1)(2) SS=E Label/Store Drugs and Biologicals Bldg. 00 F 0761 Preparation and execution of this 02/18/2025 Based on observation, interview and record plan of correction does not review, the facility failed to ensure narcotic constitute admission or agreement medications were not signed out prior to by this provider of the truth of the administration times for 7 of 11 residents reviewed facts alleged or conclusions set for medication storage. (Resident E, Resident M, forth in the Statement of Resident N, Resident R, Resident S, Resident T Deficiencies. The plan of and Resident U) correction is prepared and executed solely because it is Findings include: required by the provisions of federal and state law. On 1/27/25 at 11:24 a.m., during an observation of The facility cordially requests the 400 hall controlled drug administration records paper compliance regarding with LPN (Licensed Practical Nurse) 6, the alleged deficient practices. following narcotic medications had been signed Due to confidentiality of out but not administered: the complaint survey Resident E. -Resident E - Hydrocodone-APAP 5-325 mg M, N, R, S, T and U can't be (milligrams) signed out on 1/27/25 at 1:00 p.m. identified. -Resident M - Oxycodone IR 5 mg (2 tabs to equal All residents that have a 10 mg) signed out on 1/27/25 at 2:00 p.m. controlled substance order are at -Resident N - Oxycodone IR 10 mg signed out on risk to be affected. All controlled 1/27/25 at 2:00 p.m. substance count sheets to be -Resident R - Oxycodone IR 10 mg signed out on reviewed and assure no 1/27/25 at 1:00 p.m. medications are documented as

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-Resident S - Hydrocodone-APAP 5-325 mg

-Resident T - Oxycodone-APAP 5-325 mg signed

signed out on 1/27/25 at 1:00 p.m.

out on 1/27/25 at 1:00 p.m.

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immediately.

administered before they are

administered per MD orders, any

discrepancies will be addressed

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
155488 B. WING			01/28	/2025			
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			T JOSEPH RD		
ROLLING	G HILLS HEALTHC	ARE CENTER			LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ocodone-APAP 10-325 mg			3) DON/Designee will		
	signed out on 1/27/	25 at 1:00 p.m.			educate the licensed nurses a	ina	
	Duning on internsion	y on 1/27/25 at 11,24 n m. I DNI			qualified medication aides on	J	
	_	on 1/27/25 at 11:24 p.m., LPN already signed out her 1:00			Medication Administration and		
		medications but had not given			Chain of Custody for controlle substances Policies, emphasi		
		aware that she should not sign			on documenting medications	zirig	
	the medications out				administered the time of		
	the incurcations out anead of time.				administration on the controlle	ed	
	1. The clinical reco	rd for Resident E was reviewed			count sheet and in the EMAR		
		p.m. The diagnoses included,			4) DON/Designee will a		
	but were not limited to, major depressive disorder,				controlled substance count sh		
	right above the knee amputation and left hand				3xweek x 4 weeks, 2xweek x		
	contracture.				weeks, then 1xweek x 4 week		
					verify medications are docum	ented	
	The physician's ord	er, dated 1/7/25, indicated the			at time of administration, not p	orior.	
	resident was to rece				DON/Designee will report on		
		aminophen 5-325 mg three			audits monthly to the		
	times a day for pair	1.			interdisciplinary team for 3 mo		
					during the QAPI Meeting. The		
	_	v on 1/28/25 at 9:55 a.m., Staff			will determine if the audits are	:	
		ed the controlled drug			necessary to continue after 3		
		rd should be signed when			months with 100% compliance	Э	
	pulled from the care	d to administer.					
	On 1/28/25 at 12:30	p.m., the Regional Director of					
	Clinical Operations	provided a current, undated					
	copy of the docume	ent titled "Chain of Custody for					
	Controlled Substan	ces". It included, but was not					
	limited to, "Policy	.It is the policy of this facility					
	_	centered careSafety of					
		priorityNurses will sign both					
		on administration record) and					
		et when administering a					
	controlled substanc	e to a resident"					
		p.m., the Regional Director of					
	-	provided a current, undated					
		ent titled "Medication					
	I Administration" It	included but was not limited	1		Ĩ		I

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í	LTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILI		00	COMPLETED	
155488		B. WING	·		01/28/	2025	
NAME OF P	PROVIDER OR SUPPLIER	1			DDRESS, CITY, STATE, ZIP COD JOSEPH RD		
ROLLING HILLS HEALTHCARE CENTER					BANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		C LSC IDENTIFYING INFORMATION ion Administration Record -	1	ΓAG	DEFICIENCTI		DATE
	1	ation for medication					
	_	icyIt is the policy of this					
	facility to provide r						
	careProcedureNarcotic will be signed out when						
	given"	-					
		rd for Resident M was reviewed					
		a.m. The diagnosis included,					
		to, stage 4 sacral pressure					
	· ·	xtends through all layers of the nderlying muscle, tendon or					
	bone).	nderrying muscie, tendon or					
	oone).						
	The physician's ord	er, dated 1/14/25 indicated the					
	resident was to rece	ive Oxycodone HCl 10 mg					
	every 4 hours as ne	eded for pain.					
	3 The clinical reco	rd for Resident N was reviewed					
		a.m. The diagnoses included,					
		I to, diabetes with neuropathy					
	and rheumatoid arth						
		er, dated 1/22/25, indicated the					
		eive Oxycodone HCl 10 mg					
	every 8 hours as ne	eueu ior pain.					
	4. The clinical reco	rd for Resident R was reviewed					
		o.m. The diagnoses included,					
		to, malignant neoplasm of the					
		and recurrent depressive					
	disorder.						
	The physician's and	er, dated 1/2/25, indicated the					
		er, dated 1/2/25, indicated the cive Oxycodone HCl 10 mg					
	three times a day fo	-					
	in to announced day to	- L					
	5. The clinical reco	rd for Resident S was reviewed					
	on 1/28/25 at 1:40 p	o.m. The diagnosis included,					
	but was not limited	to, depression.					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155488	A. BUILDING B. WING	00	COMPLETED 01/28/2025		
		100700	<u> </u>	EADDRESS SITES OF STREET	01/20/2020		
NAME OF P	PROVIDER OR SUPPLIER	L.	STREET ADDRESS, CITY, STATE, ZIP COD 3625 ST JOSEPH RD				
ROLLING	HILLS HEALTHC	ARE CENTER		ALBANY, IN 47150			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE COMPLETION DATE		
F 0842 SS=E	The physician's ord resident was to rece Hydrocodone-Aceta times a day for pain 6. The clinical record on 1/28/25 at 2:10 put were not limited congestive heart fair The physician's ord the resident was to row Oxycodone-Acetar times a day for pain 7. The clinical record on 1/28/25 at 2:17 put were not limited disease, diabetes an The physician's ord resident was to rece Hydrocodone-Aceta times a day for pain This Citation relates 3.1-25(a) 483.20(f)(5), 483.7	er, dated 1/15/25, indicated the rive aminophen 5-325 mg three aminophen 5-325 mg three aminophen 5-325 mg three aminophen 7.5-325 mg three aminophen 10-325 mg three amin					
Bldg. 00	failed to ensure med reflected the admini medications for 4 or	f 11 residents reviewed for esident M, Resident N,	F 0842	Preparation and execution of plan of correction does not constitute admission or agree by this provider of the truth of facts alleged or conclusions s forth in the Statement of Deficiencies. The plan of	ment the		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	ETED
AND PLAN OF CORRECTION		155488	B. WING			01/28	/2025
				CTREET	ADDRESS CITY STATE ZIR COR		
NAME OF P	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD T JOSEPH RD		
DOLLING		ADE CENTED					
KULLING	HILLS HEALTHC	ARE CENTER		INEVV A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					correction is prepared and		
	Findings include:				executed solely because it is		
					required by the provisions of		
		rd for Resident M was reviewed			federal and state law.		
		a.m. The diagnosis included,			The facility cordially requests		
		to, stage 4 sacral pressure			paper compliance regarding		
	`	xtends through all layers of the			alleged deficient practices.		
	I -	inderlying muscle, tendon or			1) Due to confidentiality	-	
	bone).				the complaint survey Residen		
					N, O and V can't be identified.		
		ler, dated 1/14/25, indicated the			2) All residents that		
		eive Oxycodone (narcotic pain			receive controlled substance a		
		ydrochloride) 10 mg			at risk to be affected. All MAR	S	
	(milligrams) every	4 hours as needed for pain.			and controlled substance cour	nt	
					sheets to be reviewed for last	14	
	1	controlled drug administration			days to assure medications		
		e resident received the			administered were documente		
	medication on the f	following dates and times:			the controlled substance coun		
					sheet and EMAR per MD orde	ers,	
		m., 10:00 a.m. and 2:00 p.m.			any discrepancies will be		
	- 1/21/25 at 6:00 a.i	m., 10:00 a.m., 2:00 p.m. and 8:00			addressed.		
	p.m.				3) DON/Designee will		
	- 1/22/25 at 6:00 a.i	m., 10:00 a.m., 3:00 p.m. and 8:00			educate the licensed nurses a	ınd	
	p.m.				qualified medication aides on		
		m., 6:00 a.m., 10:00 a.m. and 2:00			Medication Administration Pol	icy,	
	p.m.	15.00			emphasizing on documenting		
	- 1/24/25 at 8:00 a.i	m. and 5:00 p.m.			medication in the EMAR and t		
	TT 1 2025				controlled substance count sh	eet	
	1	nedication administration			at the time of administration.		
	` /	ed documentation of the			4) DON/Designee will a		
	administration of th	ne medication.			EMAR and controlled substan		
	Dumin a au intern	or 1/29/25 at 0.55 Staff			count sheets 2xweek x 8 weel		
	_	v on 1/28/25 at 9:55 a.m., Staff			then 1xweek x 4 weeks to veri	пу	
		ed when as needed medications			controlled medications		
		ne MAR should be signed to on was administered.			administered have been	ا م	
	show the medicatio	ni was auministereu.			documented in the EMAR and		
	2 The alimination	rd Docidant N was review- 1			the controlled substance coun		
		rd Resident N was reviewed on			sheets. DON/Designee will rep	port	
		m. The diagnoses included, but			on audits monthly to the	41	
	were not limited to, diabetes with neuropathy,		1		interdisciplinary team for 3 mo	ntns	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
155488		155488	B. W	ING		01/28	/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			T JOSEPH RD		
ROLLING HILLS HEALTHCARE CENTER					LBANY, IN 47150		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE				PROVIDER'S PLAN OF CORRECTION	CTION (X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	osteoarthritis and rh	neumatoid arthritis.			during the QAPI Meeting. The		
	751 1 ' ' I 1	1 . 11/00/05 : 1: . 1.1			will determine if the audits are		
		er, dated 1/22/25, indicated the			necessary to continue after 3		
		eive Oxycodone HCl 10 mg			months with 100% compliance	9	
	every 8 hours as ne	eded for pain.					
	The January 2025 o	ontrolled drug administration					
		e resident received the					
		following dates and times:					
	- 1/22/25 at 9:00 p.i	_					
	- 1/23/25 at 6:00 a.r						
	- 1/25/25 at 8:00 a.r	-					
	The January 2025 N	MAR lacked documentation of					
	the administration of	of the medication.					
		rd for Resident O was reviewed					
		a.m. The diagnosis included,					
	but was not limited	to, depression.					
	7F1 1 ' ' 1 1	1 4 11/20/25 : 1: 4 14					
		er, dated 1/20/25, indicated the eive Morphine Sulfate (narcotic					
		25 ml (milliliters) every 4 hours					
	as needed for pain of						
	as needed for pain of	of shortness of air.					
	The January 2025 o	ontrolled drug administration					
	•	e resident received the					
		following dates and times:					
	- 1/22/25 at 8:45 a.r						
		n., 11:00 a.m. and 3:00 p.m.					
	- 1/26/25 at 12:00 p	o.m.					
		MAR lacked documentation of					
	the administration of	of the medication.					
		10.5.11					
		rd for Resident V was reviewed					
	-	o.m. The diagnoses included,					
		d to, left femur fracture,					
	diabetes and depres	sion.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/19/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLE	ETED
AND PLAN OF CORRECTION		155488	B. WING		01/28/2025	
		<u> </u>	CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R		T JOSEPH RD		
ROLLING HILLS HEALTHCARE CENTER				LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		ler, dated 12/19/24, indicated				
	the resident was to	receive Norco (narcotic pain				
	medication) 7.5-32	5 mg every 6 hours as needed				
	for pain.					
	TEL 1 2027					
	I -	controlled drug administration				
		e resident received the				
		following dates and times:				
		m., 1:00 p.m. and 8:00 p.m.				
		m., 1:00 p.m. and 8:00 p.m.				
		m., 1:00 p.m. and 8:00 p.m.				
		m., 1:00 p.m. and 8:00 p.m.				
	- 1/26/25 at 5:00 p.	m.				
	The January 2025 I	MAR lacked documentation of				
	the administration					
	the administration (or the medication.				
	On 1/28/25 at 12:30	0 p.m., the Regional Director of				
		s provided a current, undated				
		ent titled "Medication				
		included, but was not limited				
		tion Administration Record -				
		ation for medication				
	_	licyIt is the policy of this				
	facility to provide i					
		Medications will be charted				
	when given"					
	6 - ···					
	This Citation relate	es to Complaint IN00450462				
	3.1-50(a)(2)					

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