STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495068	A. BUILDING _____ B. WING _____	R-C 12/12/2019

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SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 10/22/19 through 10/24/19, was conducted 12/10/19 through 12/12/19. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 169 certified bed facility was 159 at the time of the survey. The survey sample consisted of 15 current Resident reviews (Residents #111 through #115) and one closed record review (Resident #116).	{F 000}		
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility documentation and staff interviews, the facility staff failed to administer the medication, Carvedilol as ordered by the physician and/or designee for 1 of 16 residents (Resident #105), in the survey sample. The findings included: Resident #105 was originally admitted to the facility 1/19/19 and has never been discharged	{F 658}	1. Carvedilol was obtained and administered to resident #105 as ordered. 2. All residents had the potential to be affected. MAR to card audits completed on current resident population to validate availability of medications to administer as outlined by the comprehensive care plan. MAR to card audits to be completed on newly admitted residents.	1/5/20

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

Electronically Signed | 12/18/2019

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{F 658}	Continued From page 1 from the facility. The current diagnoses included; heart failure. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/20/19 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #105's cognitive abilities for daily decision making was intact. Review of Resident #105's physician orders revealed an order which read: Carvedilol tablet 25 milligrams. Give one tablet by mouth two times daily for heart failure. Review of the Medication Administration Record revealed a note written on 12/9/19 at 16:51 (4:51 p.m.) stating the medication wasn't administered because it wasn't available to be given. An interview was conducted with Registered Nurse (RN) #3 on 12/11/19, at approximately 2:55 p.m. RN #3 stated often medications aren't available to be administered and if a note was written stating it wasn't available then; it wasn't in the medication cart. An interview was conducted with the Acting Director of Pharmacy on 12/12/19, at approximately 11:00 a.m. The Acting Director of Pharmacy stated the last time Resident #105 received the medication Carvedilol 25 milligrams from the pharmacy prior to them receiving the request 12/9/19, was 11/3/19 therefore; it was likely the medication had been out several days	{F 658}	3. Education on administering medications as outlined by the comprehensive care plan was provided to the Licensed Nurses by 12/31/19. This training will also be provided to all Licensed Nurses upon hire during orientation. 4. Ongoing audits will be conducted by the Director of Nursing and/or Unit Managers for observation and review to ensure medications are available to administer as outlined by the comprehensive care plan via MAR to card audits. These audits will be conducted 5 x weekly for four weeks, twice a week for four weeks, weekly x 2 weeks and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be	

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{F 658}	Continued From page 2 when the pharmacy received the request 12/9/19. The Acting Director of Pharmacy stated more and more the insurance companies are not authorizing refills far in advance as they did previously. Review of the unit stat drug box revealed the medication Carvedilol 12.5 milligrams was stocked and three tablets were in the box on 12/9/19. A stat box utilization record revealed two of the three tablets were removed from the stat box at 9:00 a.m., on 12/10/19, for Resident #105. On 12/12/19, at approximately 12:41 p.m., the above findings were shared with the Administrator, Director of Nursing and the Corporate consultant. An opportunity was given for the facility to present additional information but none was provided. On 12/12/19, at approximately 1:15 p.m., another interview was conducted with Registered Nurse (RN) #3. RN #3 stated on 12/9/19, the stat box was not reviewed to determine if it contained the medication Carvedilol so it could be administered to Resident #105. RN #3 further stated it never crossed his mind that particular drug would be in the stat box for usually antibiotics are the main drugs kept in the stat box.	{F 658}	completed by January 5, 2020.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		1/5/20

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F 689	Continued From page 3 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, family interview, clinical record review, facility document review and during the course of a complaint investigation the facility staff failed to ensure 1 of 16 residents in the survey sample was free from an avoidable fall from the bed during the provision of care, Resident #113. The findings included: Resident #113 was admitted to the facility on 12-20-18 with diagnoses to include stroke, contracture of left arm, and muscle weakness. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 9/10/19 coded the resident as scoring a 14 out of a possible 15 on the Brief Interview for Mental Status indicating the resident's cognition was intact. The resident required extensive assistance of 1 staff for bed mobility and personal hygiene and was totally dependent on two staff for transfers. The Comprehensive person centered plan of care identified the resident was a fall risk and had a history of a total of two falls in addition to the current fall on 11/20/19. The goal was that the resident would remain free of injury. The interventions were revised after the fall on 11/20/19 to include fall mats on both sides of the bed. Previous interventions included physical therapy evaluation, check posture while in the wheelchair, dycem to the wheelchair and observe frequently and place in supervised area when out of bed.	F 689	1. Unable to correct the deficient practice for resident #113 as fall has already occurred. Fall intervention added to the resident care plan for care of a resident with an air loss mattress. 2. 30 day review completed of falls to validate interventions were implemented to keep resident free of avoidable falls. This was completed by 12/20/19. Newly admitted residents will be evaluated to ensure interventions are in place to keep the resident free of avoidable falls. 3. Education on the Fall Prevention Policy in addition to maintaining the appropriate settings when providing care for a resident on an air loss mattress was provided to the Licensed Nurses and Certified Nursing Assistants by 12/31/19. This training will also be provided to all Licensed Nurses and CNAs upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers for observation and review to ensure interventions are in place for each resident to prevent avoidable falls and the appropriate settings are utilized when providing care for residents on an air loss mattress. These audits will be conducted 5 x week for two weeks, weekly for two weeks and monthly for three months. All data will be summarized and presented to	

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F 689	Continued From page 4 A Facility Reported Incident was sent to the State Agency on 11/20/19 indicating the resident fell during the provision of ADL (activities of living) care. No injury was noted. An investigation was underway. Both Certified Nursing Assistants (CNA) involved with the fall were suspended. The facility final investigation summary indicated the fall was due to a combination of soap and water while bathing the resident and incorrect setting on the air loss mattress. Education was provided to one of the CNA's involved and the second CNA was terminated based on this action and another allegation involving a different resident. The summary indicated the resident had sustained two fractured ribs as a result of the fall per the X-rays obtained at the facility on 10/24/19. The mobile X-ray report dated 11/24/19 conclusion: Acute left 4th and 5th rib fractures, old healed right lateral rib fractures were noted. On 10/24/19 the resident was sent to the Emergency Room (ER) at a level 1 trauma center for evaluation of complaints of shortness of breath and pain to the left rib. While there the resident underwent multiple diagnostics to include; a chest X-ray and CT of the chest. Both the X-ray and CT came back negative for acute fracture of the left ribs. The resident was sent back to the facility the same day with new orders for left rib pain management with Ultracet 37.5-325 mg (milligram) one tablet every six hours as needed for pain. This medication was changed to Tramadol 50 mg one tablet every six hours as needed on 11/27/19 due to insurance issues. The Medication Administration Record's (MAR's) for November and December 2019 evidenced the resident was medicated once for	F 689	the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by January 5, 2020.	

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left rib pain on 11/28/19, 11/29/19 and 12/10/19.

On 12/10/19 at 11:25 a.m., the resident was observed asleep in bed on a low air loss mattress. The setting was on the appropriate therapy setting. The bed was in the low position and floor mats were observed on both sides of the bed. At 1:56 p.m., the resident was observed awake in bed, the low air loss mattress was set in the appropriate setting, the bed was in the lowest position and the floor mats were in use. The resident was interviewed and stated he did have a fall out of the bed, but could not recall the exact cause of the fall. The resident was asked if he was experiencing any pain and stated, "Yes", he then pointed to the left side of his chest and rated the pain a 6-7 out of a possible 15. The nurse assigned to the resident was informed of the resident's complaint of pain and the resident was administered the 12/10/19 dose of Tramadol 50 mg.

On 12/10/19 at 1:08 p.m., the Director of Nursing (DON) was interviewed. She was asked what was the root cause of Resident #113's fall on 11/20/19. She stated that from her investigation the staff failed to put the low air loss mattress setting to "hard", and when the second CNA stepped away to discard the soiled bed linen the air in the mattress fluctuated and it "pushed the resident off the bed". She further stated, "When they go in to do care we tell them to put the bed on hard (autofirm)...this probably would not have happened if she (CNA) would have put it on hard because the resident is not able to roll himself". She stated as a result of the fall staff on that unit were educated by the unit manager and staff educator on "how to take care of a resident on a low air low mattress". The DON stated that during

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F 689	Continued From page 6	F 689		

orientation the staff are educated on how to take care of a resident on a low air low mattress. She also stated the daughter came in that same day and was upset and reported the fall to Adult Protective Services (APS). APS came to the building later that same day and recommended placement of the fall mats. The DON also stated a new fall intervention was to maintain the bed in the lowest position. A request to review evidence that staff are provided education during orientation on the use of the low air loss mattress while providing care. Prior to exit the DON stated education on the use of the low air low mattress was not included in orientation.

On 12/10/19 at 1:49 p.m., the staff educator was interviewed. She stated when moving a resident in a low air loss mattress the setting should be placed on autofirm first, this allows for the bed to be a completely flat surface. If the mattress is not placed on autofirm different areas of the bed will inflate which could potentially make a resident roll out of the bed.

On 12/11/19 at 9:45 a.m., CNA #1 was interviewed. She stated that while she was washing the resident's back the other CNA walked towards the door to put soiled linen into the barrel located outside the door. She stated that the resident was on his right side near the edge of the bed "the bed inflated on one side...he fell off the bed...it happened so quickly...I always need someone to help turn him". When asked if she had ever had any education on turning a low air mattress setting to autofirm while providing care she stated she had not prior to this incident.

On 12/11/19 at 11:06 a.m., the resident was observed asleep in bed, the low air loss mattress

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F 689	Continued From page 7	F 689		

was set in the appropriate setting, the bed was in the lowest position and the floor mats were in use.

On 12/11/19 at 12:50 p.m., the Nurse Practitioner was interviewed. She stated she examined the resident on 12/3/19 and did not find any evidence of bruising to the residents left chest area. When asked about the chest X-ray taking at the facility with findings of acute fractures to the left ribs in comparison to the ER findings, she stated, "It is not common, but I have seen it with mobile X-rays...we sent him out to be evaluated...there was no documentation from the ER of a lung contusion, it would show up on the CT scan...the CT is more definitive and was negative for acute fractures."

The low air loss mattress instructions provided by the facility read, in part: Autofirm mode provides maximum air inflation designed to assist both residents and caregivers during resident transfer and treatment...When using the mattress system, always ensure that the resident is positioned properly within the confines of the bed...it may be helpful to activate the Autofirm mode to achieve a firm surface for repositioning purposes.

The above finding was shared with the Administrator, the DON and the Nurse Consultant during the pre-exit meeting on 12/12/19 at 12:45 p.m.

The facility was given ample time to provide additional information prior to exit. No additional information was provided to the survey team for this deficiency.

Complaint deficiency.

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{F 755} SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must 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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility documentation review the facility's staff failed to ensure the medication Seroquel was available to be administered as ordered to 1	{F 755}	1. Seroquel was obtained and administered as ordered to Resident #108.	1/5/20

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{F 755}	Continued From page 9 of 16 residents (Resident #108) in the survey sample. The findings included: Resident #108 was admitted to the facility on 4/4/2017 with diagnoses to include but not limited to Schizoaffective Disorder and Bipolar Disorder. The most recent Minimum Data Set (MDS) was a Quarterly with an Assessment Reference Date(ARD) of 11/27/19. The Brief Inter for Mental Status was coded as a 14 out of a possible 15 which indicated Resident #108 was cognitively intact and capable of daily decision making. Under Section N Medications, N0450 Antipsychotic Medication Review Resident #108 was coded a 1 indicating antipsychotics were received on a routine basis. Resident #108's Comprehensive Care Plan was reviewed and is documented in part, as follows: Problem: Start Date 10/8/2019 Category: Psychotropic Drug Use Resident receives antipsychotic medication Seroquel 100mg (milligrams) BID (twice a day) due to Schizophrenia/Bipolar Disorder. Resident #108's current Physician Orders dated 12/1/2019 were reviewed and are documented in part, as follows: Start Date: 10/7/19- Open Ended Seroquel-Schedule II capsule; 100 mg oral (DX (diagnosis): Schizoaffective disorder, bipolar type) Twice A Day; 4:00-06:00, 17:00-19:00. Resident #108's Medication Administration	{F 755}	2. All residents had the potential to be affected. Audit completed for medication availability on the current resident population to ensure medications are available to be administered as ordered. MAR to card audits were also completed for the current resident population to ensure medication availability. This was completed by 12/27/19. Medication availability along with MAR to card audits will be verified and conducted on all newly admitted residents. 3. Education on Medication Procurement to include medication availability and MAR to card audits was conducted with the Licensed Nurses by 12/31/19. This training will also be provided to all Licensed Nurses upon hire during orientation. 4. Ongoing audits by the Director of Nursing and/or Unit Managers will be conducted for observation and review to ensure medications are available to be administered as ordered to include running a medication not available report and performing MAR to card audits. These audits will be conducted 5 x weekly for four weeks, twice weekly for two weeks, and weekly for two weeks and monthly for three months. All data will be summarized and presented to the facility Quality Assurance and Performance Improvement meeting monthly by the Administrator. Any issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued	

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{F 755}	Continued From page 10 Record (MAR) dated 12/8/19 through 12/10/19 was reviewed and is documented in part, as follows: Seroquel-Schedule II capsule; 100 mg oral 12/9/2019 04:52 A.M. Not Administered: Drug/Item Unavailable, Created By: LPN (Licensed Practical Nurse) #3. Seroquel-Schedule II capsule; 100 mg oral 12/10/2019 06:36 A.M. Not Administered: Drug/Item Unavailable, Comment: reorder Created By: LPN (Licensed Practical Nurse) #4. The facility Stat Mediation Box was reviewed and the medication Seroquel was not available in the box. On 12/10/19 after reviewing the above information with the facility Nurse Consultant, she was asked to bring any further information regarding Resident #108's Seroquel not being available on 12/9/19 and 12/10/19. On 12/11/19 LPN #1 provided the surveyor with a F-755 Unavailable Medication Tool Audit dated 12/10/19 that was removed from the facility's Plan of Correction Book in the conference room which was reviewed and is documented in part, as follows: Resident Name: Resident #108 Medication Unavailable: SEROQUEL Action Taken: Stat Out-Cart LPN #1 also provided a copy of the Pharmacy Facility Billing Authorization that was dated and signed on 12/10/19 by the Director of Nursing for two Seroquel 100 mg capsules for Resident	{F 755}	compliance. The QAPI committee consists of the Administrator, DON, Staff Development Coordinator, MDS coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, and Environmental Services. Other members may be assigned as the need should arise. 5. The Administrator and the Director of Nursing is responsible for implementing and maintaining the acceptable plan of correction. Corrective action to be completed by January 5, 2020.	

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{F 755}	Continued From page 11	{F 755}		

#108.

A Pharmacy Shipping Manifest for Resident #108's two delivered Seroquel capsules was reviewed and indicated that the medication was received in the facility on 12/10/19 at 23:38 (8:38) P.M..

Resident #108's progress noted dated 12/11/19 at 11:02 A.M. completed by LPN #1 was reviewed and is documented in part, as follows:

Name NP (Nurse Practitioner), into view patient on 12/10/19; NP was made aware that the patient has missed 2 doses of Seroquel-pharmacy was notified; the medication was sent to the facility STAT, the complete 30 day supply is scheduled to be delivered today per the pharmacy representative,
Name-mother/RP(responsible party) aware-will continue to follow-up.

On 12/11/19 at 11:05 A.M. an interview was conducted with LPN #1 regarding Seroquel that was unavailable on 12/9/10 and 12/10/19. LPN #1 was asked how she determine the medication was not available. LPN #1 stated, "By doing the daily audits. I saw the drug was not available and I had the pharmacy stat 2 pills over yesterday that we paid for because they were waiting for insurance approval." LPN #1 was asked for the daily unavailable medication audit for 10/9/19 which was not in the Plan of Correction Book. LPN #1 stated, "I will have to see if I can find it."

On 12/11/19 at 12:10 P.M. an interview was conducted with the Director of Nursing regarding Resident #108's unavailable Seroquel on 12/9/19 and 12/10/19 and what she would have expected

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	495068	A. BUILDING _____ B. WING _____	R-C 12/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF NORFOLK	1005 HAMPTON BLVD NORFOLK, VA 23507

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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to have happened. The Director of Nursing stated, "I would have expected an audit to have be done on 12/9/19 and to have caught it and to have alerted that pharmacy then. I communicated to the pharmacy that if there are insurance issues to go ahead and send the medicines and we will pay for it. There is still a communication breakdown."

On 12/11/19 at 1:00 P.M. a phone interview was conducted with LPN #4 regarding Resident #108's Seroquel not being available on 12/10/19. LPN #4 stated, "I did not have his Seroquel at 6 A.M. on 12/10/19, so I hit the reorder button that goes directly to the pharmacy. I also reported to the oncoming nurse that we were out of it."

On 12/11/19 at 2:00 P.M. a phone interview was conducted with LPN #3 regarding Resident #108's Seroquel not being available on 12/9/19. LPN #3 stated, "It was not available, I hit the button to reorder it through the pharmacy. I also passed it on in report and gave a list of a couple other medications that needed to be delivered. I'm also a psychologist and based on the Resident's (Resident #108) diagnoses he needs this medication."

On 12/11/19 at approximately 2:00 P.M. the Director of Nursing provided the surveyor with a F-755 Unavailable Medication Tool Audit dated 12/9/19 that was completed by LPN #1. The Director of Nursing was asked where was the audit located. The Director of Nursing stated, "Name (LPN #1) just walked out of her office and handed it to me."

The F-755 Unavailable Medication Tool Audit dated 12/9/19 that was completed by LPN #1 was

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reviewed and is documented in part, as follows:

Resident Name: Resident #108
Medication Unavailable: SEROQUEL
Action Taken: Pharmacy Called

On 12/11/19 at 2:15 P.M. an interview was conducted with LPN #1 regarding the F-755 Unavailable Medication Tool Audit dated 12/9/19. LPN #1 was asked why wasn't the medication stated out on 10/9/19 instead of 10/10/19 based on the audit that indicated the medication was not available. LPN #1 stated, " On 10/9/19 I spoke to Name (Pharmacy Technician) and was told that it would be here that evening."

On 10/12/19 at approximately 11:23 A.M. a phone interview was conducted with the Pharmacy Technician and the Acting Pharmacy Director. The Pharmacy Technician was asked if she had spoken to LPN #1 on 12/9/19 regarding the medication Seroquel not being available. The Pharmacy Technician stated, "I do not recall taking to her (LPN #1) on 12/9/19 but she did call on 12/10/19 around 2:00 P.M. about the resident being out of Seroquel. It is our policy to document and screen shot all phone conversations and I have that for my conservation with her on 12/10/19. She (LPN #1) said that they were out of compliance because he (Resident #108) was out of Seroquel and State Surveyors were in the building. I told her that the pharmacist said it can't be filled until the following day because it was too early. I sent over an authorization form that was sent back and we sent 2 Seroquel pills over that the facility agreed to pay for." The Acting Pharmacy Director stated, "We sent a 30 day supply of the Seroquel over on 11/15/19 that should have carried the resident

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through 12/15/19 that is why the insurance was not approving it. I also am not aware of any agreement that we will automatically send needed medications to the facility that are insurance denied. It is also out policy to document and screen shot all phone conversations with the facilities and I do not see on for 10/9/19 for the resident's Seroquel."

The Pharmacy Technician's Pharmacy Order screen shot and documentation regarding Resident #108's Seroquel discussion with LPN #1 time stamped 12/10/19 at 14:52:22 (2:52) P.M. was reviewed and is documented in part, as follows:

Spoke with Name (LPN#1) whom stated will need to get 1 day supply billed to facility and STAT

The facility policy titled "Medication Ordering and Receiving From Pharmacy Provider, Ordering and Receiving Non-Controlled Medications" dated 9/2010 was reviewed and is documented in part, as follows:

POLICY: Medications and related products are received from the provider on a timely basis. The nursing care center maintains accurate records of medication order and receipt.

PROCEDURES:
1. Ordering medications from provider pharmacy:
b. Reorder routine medications by the re-order date on the label to assure an adequate supply is on hand.

On 12/12/19 at 12:41 P.M. a pre-exit conference was held with the Administrator, the Director of Nursing and the Nurse Consultant where the

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{F 755}	Continued From page 15 above information was shared. The Director of Nursing stated, "If I had known the medication was missing on the 9th, I would have called the pharmacy and realized we have received a 30 day supply on November 15th. Then I would have made sure the resident had his medications and begun an investigation to find the missing pills." Prior to exit no further information was provided.	{F 755}		