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S 000	Initial Comments Complaint Investigation: 2086783/IL126225 2085750/IL125036 2084927/IL124167 2083946/IL123130 2083731/IL122910 2083521/IL122688 2089321/IL129020 2089429/IL129145	S 000		
S9999	Final Observations Licensure Violation #1 Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210c)4)A)B) 300.1210d)6) 300.1230a)1)2)3) 300.1230b) 300.1230d)1) 300.3240a)1) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in	S9999	**Attachment A** **Statement of Licensure Violations**	

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S9999	Continued From page 1 operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. B) Each resident shall have at least one complete bath and hair wash weekly and as many additional baths and hair washes as necessary for satisfactory personal hygiene. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the	S9999		

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S9999	Continued From page 2 following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1230 Direct Care Staffing a) For the purposes of this Section, the following definitions shall apply: 1) Direct care is the provision of nursing care or personal care as defined in Section 300.330, therapies, and care provided by staff listed in subsection (f). 2) Skilled care is skilled nursing care, continuous skilled nursing observations, restorative nursing, and other services under professional direction with frequent medical supervision. 3) Intermediate care is basic nursing care and other restorative services under periodic medical direction. b) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs on each shift of the day. d) Each facility shall provide minimum direct care staff by:	S9999		

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S9999	Continued From page 3 1) Determining the amount of direct care staffing needed to meet the needs of its residents Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on interview and record review, 1) the facility failed to provide adequate supervision during meal time for 2 of 3 residents (R7 and R9) reviewed for assistance during meal time. This failure affected R7 and R9 and has the potential to affect all 32 residents identified as needing assistance during meal time. R7 has a diagnosis that includes Dysphagia and R9 has a diagnosis that includes Quadriplegic. This failure put R7 and R9 at risk for aspiration and choking. 2) Based on interview and record review, the facility failed to document and promote good hygiene and to ensure that the resident receives treatment and care related to residents needs. This failure affected R7 & R9 reviewed for quality of care. Findings include: On 11/30/20 at approximately 11:13am, R9 was observed in his room seated in an electric wheel chair, R9 complained to the surveyor he was not receiving quality care. R9 stated he is dependent on staff's assistance with feeding during meal time and no one is helping him. R9 stated his	S9999		

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restorative care was not being done. R7 was observed in bed across from R9. R7 stated, They (referring to nursing staff) don't help with setting up my tray, they just put it on the bedside table and I can't reach it. R8 or R29 help set me up and will help feed me if I need help."

R9 stated the facility have been using agency staff who are not familiar with the necessary care he needs so they don't know what to do. R9 complained regarding the feeding issue several days in the last two weeks, the staff will leave the food tray on the bedside table. R9 stated that when R8 saw this R8 decided to help feed him (R9). R9 stated after R8 has finished feeding himself he will come and help in feeding him. R9 stated at times R29 will come to feed him because he was unable to use his fingers to grab the utensils on the food tray. Most times the necessary adaptive devices are not provided to aid in feeding. R9 stated the adaptive feeding devices are not placed on the tray. R9 stated he complained to V8 (Restorative Director) about it, V8 told him that there is nothing he can do about it because there is a strike going on.

On 12/06/20 at 12:22 pm, R8 "I help them (and points to R9 and R7). Every day the CNAs come here, they put the tray on their tables and leave. They don't open the milk, the juice. If they have hard-boiled eggs, they don't open it. Then I help them (R9 and R7). I open the milk carton, I put the straw in the juice, I open the boiled eggs. Sometimes R7 can't feed himself. He got a lot of shaking, so I feed him. Before, there were 2 CNAs in the evening, now sometimes there is no CNA. Sometimes I have to pull R7 up in bed. They told me not to do it, but when I asked the CNA to do it two days ago, because he was slipping down, she got mad. Sometimes R7 calls

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me and says "I need to be changed, I'm wet. Sometimes in the middle of the night, then I say I'll go get the CNA, but they are not there, then I go to pick up the diapers and change him. They don't move him. He always on his back. These people are from agencies. They don't have the experience or they don't care."

On 12/06/20 at 12:32 pm V41 (Certified Nursing Assistant- CNA) states I'm agency, I didn't have any training. You just show up for the job."

On 12/06/20 at 1:38 pm V41 (agency CNA) states "This is my second time here, but weeks apart. R9 can feed himself. He is just a set-up, you know open his food, milk cartoon, juice. He got something in his hand. I have no idea who puts the device on his hand, probably restorative? He can't put it on himself. I have not put it on his hand. I did not give him a shower today. The last time I had him I gave him a bed bath." V41 couldn't tell the date. "Honestly, I have no idea why he is not getting his shower. I don't know what is going on."

On 12/6/20 at 12:00 pm, R9 states "I usually have a shower (bed bath) on Tuesdays and Fridays. For two weeks I haven't had a shower at all. They don't want to do it. Every day is a new Certified Nursing Assistant (CNA), and they don't want to give me a bed bath. I did not ask to have a shower today, because if I do ask out of my scheduled days they will say "It is not your day to have a shower (bed bath)." I don't remember the name of the CNA, it was an agency CNA. I never had a shower in the shower room. They say they don't have enough people to give me a shower. Last Friday I asked, can you please at least wash my underarms? They did, but if I don't ask, they do nothing. Before the strike, sometimes they

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would feed me. If I have the tool, I can feed myself. Last week I didn't have it, and CNAs did not feed me. R8 fed me. He and my friend (R29), they are the ones who helped me."

R8 stated that both R7 and R9 are not being cared for in a timely manner, R8 stated he had to feed them and at times perform incontinent care for R7. R8 stated both R7 and R9 are not getting restorative care. R8 stated in part the staff will place R7 and R9's food tray on their bed-side table and they will not come back to fed them.

Review of video submitted anonymously shows R9 being fed by another resident R29. R29 is not trained in feeding techniques and is feeding R9 without staff supervision.

On 12/1/20 at 11:50am, V8 (Restorative Nurse/ Director) stated, that restorative programs are provided by the CNA (Certified Nurse's Aide) assigned to each resident. V8 stated the CNA's are trained in performing the task involved in the restorative programs that includes but not limited to AROM active range of motion), PROM (passive range of motion), Eating and ADL's. When the surveyor asked V8 who monitors these tasks to ensure they are provided and done utilizing proper techniques, V8 replied V2 DON (Director of Nurses) and V5 ADON (Assistant Director of Nurses).

On 12/1/20, V8 presented R7 and R9's Look Back Report on restorative program that shows that these tasks were not being done. AROM not done 11/28/20, 11/29/20, 11/30/20 and 12/1/20. No entry under bathing and assisting with eating from 11/16/20 to 12/1/20. When the surveyor asked what the entries on the report represented, V8 stated it's not being done, referring to R7 and

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S9999	Continued From page 7 R9 not receiving a bath, not being monitored/supervised during meal time, and not getting assistance to eat. V8 explained that R9 needs adaptive devices for holding utensils to feed himself partially. V8 stated one of the staff still need to assist him in picking up the residuals from the plate and in drinking from the cup or a milk carton. On 12/2/20 at approximately 12:56pm, R29 was noted during lunch time trying to wheel herself into R9's room asking R9 if he had eaten. When R29 saw the surveyor in the hallway by R7 and R9's room while the CNA (Certified Nurse's Aide) was feeding R9, R29 stated "Hum, they are feeding him now." R8 and R29 then told the surveyor that R29 has been helping feed R9 every day, they both explained that the CNA's just place the food tray on the table and walk away when the surveyors are not in the facility. R8 stated at times it takes 40 minutes to 1 hour for the staff to come back into the room. R29 stated the nurses (referring to nurses and CNA's) don't come to feed R9. R9's facility tool used in assessing the residents MDS (Minimum Data Set) dated October 8, 2020 section G Self-Performance coded R9 as 3/2 for eating which shows that R9 needs extensive care with one person physical assistance. Under section G0400 for functional limitation R9 was coded 2 for upper extremities and 2 for lower extremities which showed that R9 has impairments on both sides that interferes with daily functioning or placed R9 at risk for injury. R9 BIMS (Brief Interview Mental Status) recorded as 15 indicating R9 is cognitively intact. On 12/3/2020 at approximately 1:15pm R8	S9999		

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stated, I feed him referring to R7 and sometimes him referring to R9, no one comes to feed them. They wait over one hour and a half for food. I make sure they eat.

On 12/4/20 at 2:48pm, V22 (Speech Therapist) during interview stated she was working with R7. V22 stated R7 was complaining that he could not clear something out of his throat so a swallowing evaluation was done. V22 stated R7 has history of dysphagia. When the surveyor asked whether it is appropriate for another resident to feed R7 during meal time, V22 replied that's not in my field but I disagree with that (referring to residents feeding each other during meal time).

On 12/4/20 at approximately 3:15pm, V45 (Physician) was interviewed, V45 stated R9 had a stroke history and it is a standard of practice for R9 to have therapy. When asked about whether it is appropriate for another resident in the facility to feed R9 during meal time, V45 stated I'm a professional I will never give an order to have R9 fed by another resident. R9 should be fed by either a CNA (Certified Nurse's Aide) or a Nurse (referring to a licensed Nurse). V45 explained that he is a firm believer in PT, OT and restorative therapy and that is why he routinely ordered rehab (Rehabilitation) therapy for R9 to prevent further contractures, improve his skills in daily living and prevent him from falls because R9 is also at risk for falls.

On 12/06/20 at 12:59pm, surveyor observed V42 RN (Registered Nurse) go into R9's room placing the lunch tray on R9's side table and left the room and did not assist in setting up the food on the tray and did not ask whether R9 needed help. R9 was noted with hand strap (adaptive Device). R9 told the surveyor that R8 helped him in applying

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S9999	Continued From page 9 the device. On 12/7/20 at 10:20am, V46 OT (Occupational Therapist) was interviewed. V46 stated she is responsible for assessing all the residents in the facility in regards to occupational therapy. V46 stated R7 had issues with swallowing, a goal for self-feeding with set up and staff supervision was put in place. V46 stated R7 is now in a rehab program. V46 explained that R7 was in OT for approximately four weeks. V46 stated R9 uses a universal cuff to hold utensils, guard plates (adaptive equipment) in eating. When the surveyor asked V46 about the facility protocols concerning residents assisting in feeding another resident during meal time, V46 replied, during this pandemic I will not recommend that residents feed each other. V46 further stated "we have care staff to do that (referring to the task). V46 stated she did not witness any resident feeding R7 or R9. On 12/7/20 at 10:35am, V2 DON (Director of Nurse's) was interviewed concerning facility protocol on supervision and assisting residents in feeding tasks at meal time. V2 stated the CNA's and the licensed nurses are responsible in assisting residents during meal time. When asked about whether it is appropriate for residents to feed each other during meal time, V2 replied it is not a safe situation because how will the resident know what the other resident can tolerate or what was ordered? V2 stated the OT department evaluates the resident and let's the nursing department know what each resident needs. V2 stated it is not safe for a resident to feed each other due to the risk of aspiration and choking. V2 stated none of the staff has informed her that residents are feeding each other during meal time.	S9999		

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On 12/1/20 at 4:03pm, V5 stated V8 is responsible for making sure the restorative programs are being done with each resident and in charge of making sure the charting on assistance rendered are charted correctly in the resident's chart. V5 stated feeding assistance should be done by CNA's and licensed nurses.

On 12/7/20 at 11:13am, V22 (Speech Therapist) was interviewed concerning the reason for having a swallowing evaluation done, V22 replied there are lots of reasons like pneumonia but if you're talking about R7, he was having food caught in his throat. The surveyor asked V22 in her professional opinion, is it appropriate for a resident to feed another resident and what are the risks of residents feeding each other without supervision and training? V22 stated I will not advise that residents feed each other because there are lots of things that can happen like aspiration and choking.

On 12/7/20 at 11:31am, V36 NP (Nurse Practitioner) stated R7 had an old diagnosis of dysphagia but R7 is improving. When the surveyor asked V36 in his professional opinion should R7 be assisted in feeding during meal time by another resident? V36 replied, No it should be the staff feeding R7 and any other resident (referring to CNA's and Licensed Nurses).V36 explained that during this COVID-19 pandemic residents are at risk for spread of COVID-19, aspiration and choking.

R7's MDS (Minimum Data Set) facility assessment tool used in assessing residents dated showed that R7 had a BIMS (Brief Interview for mental Status) score of 14
R8's MDS (Minimum Data Set) facility

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assessment tool used in assessing residents dated December 8, 2020 showed that R8 had a BIMS score of 15.
R29's MDS (Minimum Data Set) facility assessment tool used in assessing residents dated October 14, 2020 showed that R29 had a BIMS score of 14.

R7's order summary showed that R7 is on swallowing precautions effective 10/08/20 with no end date.

R7's speech therapy notes dated 10/8/2020, V22 (Speech Therapist) documented that R7 was under her care and found to have a swallowing disorder involving the oral phase, pharyngeal phase and the esophageal phase. V22 documented that R7 has a history of aspiration Pneumonia and definite risk for aspiration, choking and a delayed or slow swallowing reflex. V22 recommendations includes but not limited to Dysphagia treatment, and a Video-fluoroscopic swallow study. V22 was not sure whether the video-fluoroscopic swallow test was done.

On 12/10/20, the facility presented Modified Barium Swallow study final report dated 5/22/2019 that listed pertinent medical history diagnosis that includes but not limited to Oropharyngeal Dysphagia. Summary of the evaluation showed R7 marked for oral phase mild, pharyngeal phase mild and recommendations for diet to be Mechanical soft with thin liquids. No current test results were presented.

On 12/16/20 at 10:45am, R29 told the surveyor she was not trained on feeding techniques and did not know what to do if a resident is choking or aspirates. At 10:47am, R8 also was interviewed

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in regards to education received when assisting in feeding resident with dysphagia and stroke and what to do if resident is choking or aspirates. R8 stated he had no training and would not know what to do.

On 12/16/20 at 10:51am, when asked V8 (Restorative Director)whether R8 and R29 were trained in feeding techniques and on what to do when a resident is choking or aspirated. V8 replied, R8 and R29 were not trained because the facility does not train residents to assist in feeding their peers. Only the resident who is on swallowing precautions and assistance is trained to prevent aspiration and promote their independence with feeding. V8 then explained again that we (referring to staff) don't train residents on restorative programs, R8 and R29 were not trained.

On 12/16/20 at 11:00am, during interview with V45 (physician), when asked in V45's professional opinion what is the risks with R9 being fed by peers who are not trained in feeding techniques in residents with a stroke and dysphagia. V45 stated I don't condone it, it's not a good idea. V45 explained that R9 had a stroke which makes dysphagia a probability and R9 can choke or aspirate. V45 stated the peers can feed an improper diet not equal the specific diet recommended which can result into malabsorption because the roommate wants to please R9.

The facility Job Description for position title Restorative Nurse presented with no date documented that the Restorative Nurse is responsible for development, implementation, monitoring and supervision of the restorative nursing program for the facility. Ensure that the

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S9999	Continued From page 13 necessary assistive feeding and or ADL devices are obtained as needed. Make in sure daily rounds are done to oversee and monitor the restorative programs. And reports to the DON. The facility policy and procedure on Feeding Assistance presented with no date pointed out in part that the purpose of the policy includes but not limited to feeding techniques will be coordinated with the speech therapist as needed. The facility policy and procedure for Restorative Nursing Programming with no date pointed out that the facility must have evidence that staff and volunteers carrying out restorative programs must be supervised under a licensed nurse. And there is a written evidence that staff and volunteers carrying out the programs have been trained in techniques (Competency training). (B) Licensure Violation #2 Statement of Licensure Violations: 300.610a) 300.1010h) 300.1210b) 300.1210c)1)3) 300.1630d) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a	S9999		

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S9999	Continued From page 14 Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative	S9999		

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S9999	Continued From page 15 measures shall include, at a minimum, the following procedures: c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation and a notation made in the resident's record. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These Regulations were not met as evidenced by: Based on observation, interview and record review, 1) the facility failed to conduct comprehensive assessments and provide appropriate services needed relating to	S9999		

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complaint of chest pain; failed to administer routine medication in accordance with the established medication administration of within 60 minutes of the scheduled time for one of three residents (R11) in the sample reviewed for pain. This failure affected R11 who has a pain score of 10, chest pain, headache, facal grimacing and did not recieve any interventions for pain. R11 was sent to the local hospital and admitted with diagnosis that includes: Chest pain, Headache and SOB (Shortness of Breath).

Findings include:

R11's medical record face sheet documented that R11 was originally admitted to the facility on 2/18/20 and the latest admission was 10/29/20 with diagnosis that includes but not limited to Essential primary Hypertension, Polyosteoarthritis, Schizoaffective Disorder Depressive type, Pain right hip and Pain left hip.

On 11/30/20 at 11:00am, R11 is noted in her room, in bed. R11 has facial grimacing, holding her chest and appears to be in discomfort/pain. Surveyor asked R11 on a scale of 1-10 what is her pain level? R11 stated, "Pain is a "10". When asked what kind of pain are you having, R11 replied "chest pain". R11 stated the pain is from not getting her blood pressure medication in the past three to five days and now she is having chest pain and a headache. R11 stated she told V20 LPN (licensed Practical Nurse) about it and she (V20) is not doing anything about it. When the surveyor approached V20 about the complaint, V20 stated that R11 has refused her medication. As V20 was about to walk away, R11 said to her I did not refuse my medicine, I refused the psych-medicine but I know I need my blood pressure medication. R11 stated my Metoprolol

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and Hydralazine. At 11:07am, R11's blood pressure read 163/88, pulse 78 and respirations 18. V20 then stated these medications are not available that she will have to go and get them from the convenient box. The surveyor then asked V20 what is the standard recommended time for medication administration in nursing and the facility protocol on medication administration. V20 replied medications should be administered one hour before and one hour after scheduled time. V20 then stated the medication was late because it was not available in the medication cart. When the surveyor asked V20 about physician notification about R11 refusing her scheduled medicine, V20 replied, R11 is known for refusing medicine.

Review of R11's chart did not show any PRN order of medication to be administered for chest pain. V20 stated, there is no order recorded for PRN medicine. V20 then stated I'm going to call the physician now and the V2 DON (Director of Nurses).

Review of R11's medical records progress note dated 11/30/20 timed 13:16 (1:16pm) showed that Hydralazine HCL (Hydrochloric) tablet 25mg was not administered until 1:16pm, three hours sixteen minutes past the scheduled time.

R11's Interdisciplinary Plan of care showed that R11 is at risk for elevated blood pressure. Blood pressure should be maintained within normal limits with interventions that includes but not limited to administering medication as ordered and monitoring for symptoms that includes headache, SOB (Shortness of Breath), chest pain or lightheadedness with last revised date 11/7/20.

R11's plan of care for pain documented that R11

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has the potential to have pain related to co-morbidities. Under the goal it was pointed out that R11 can have episodes of pain and it should be rated at less or equal to 2 within one hour of intervention. Interventions includes but not limited to assessing pain level on the 1-10 scale.

On 12/4/20 at 2:16pm, in an interview with V36 NP (Nurse Practitioner), asked about what can happen to a resident with an order to receive anti-hypertensive medications and the medication is unavailable and is not administered at the right time? V36 stated that, when the antihypertensive medications are not given or not given at the right time, the resident can develop high blood pressure with symptoms of chest pain, headache and distress. V36 stated the medication should be readily available at all times even when the resident is refusing to take them just in case the resident decided to change their mind. When the surveyor asked V36 about what the nurse should do with a resident complaining of chest pain, V36 replied stating that when a resident experiences these symptoms with complaint of chest pain, it is an automatic referral to the hospital. V36 stated Chest pain is not something to be taken lightly. At 2:42pm, when asked V36 that in his professional opinion about R11 not having any PRN (As needed) medication on a stand by order for treatment of chest pain. V36 replied, I now started (R11) on low dose aspirin.

On 12/7/20 at 10:35am, an interview with V2 DON (Director of Nursing) concerning the facility protocol on medication refills. V2 stated when any medication is getting low to about four tablets the nurses should pull the re-order tab and send the same day to the pharmacy or make a telephone call to pharmacy. When the surveyor's observation about R11 not having Metoprolol and

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S9999	Continued From page 19 Hydralazine medication available and not administered at the right time, V2 stated R11's medication should be available at all times. V2 stated, there is facility convenient box where medications are kept for emergency use. V2 stated V20 should have given these medications at the right time and should have checked the convenient box. V2 stated medications are professionally acceptable within one hour before and one hour after the scheduled dose. When asked V2 about the facility expectation of licensed nursing staff when a resident complains of chest pain. V2 stated the licensed nurses should assess the resident by taking the vital signs (referring to blood pressure, respiration, and temperature). V2 stated based on assessment, an emergency telephone call should be placed to send the resident to the hospital for further assessment and also call the attending physician. V2 stated R11 should have been sent to the hospital in a timely manner for the complaint of chest pain and headache. The facility policy on Management of Pain presented with no date documented in part that the mission of this policy is to promote resident comfort and preserve resident's dignity. The purpose is to accomplish this mission includes but not limited to providing effective pain management program and provide residents means to necessary comfort. Procedure includes but not limited to nursing involvement that includes comprehensive pain assessment. The facility policy on Ordering Medication presented dated December 2018, stated that medications and related products are to be ordered in a timely basis. Procedure includes but not limited to requesting refill medications 72 hours prior to the last dose.	S9999		

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S9999	Continued From page 20 The facility policy presented on Physician Orders (Following Physician Order) with no date documented in part that it is the policy of the facility to follow the orders of the physician. The facility policy titled 2.6a Ordering Medications (Electronic) with no date documented that the medications and related products are ordered on a timely basis and procedure includes but not limited to re-ordering medications three days (A)	S9999		