STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

(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
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the nurse practitioner, Resident #3 and family, the facility staff, the facility failed to coordinate the return transportation for 1 of 1 resident (Resident #3) back to the facility. Findings included: The most recent Minimum Data Set (MDS) dated 7/14/16 revealed Resident #3 was admitted on 7/5/16 and was cognitively intact with the diagnoses of ascites (fluid in the stomach), cirrhosis(liver disease), severe esophagitis, chronic pain syndrome and portal gastropathy(stomach condition). Review of the transportation calendar for the days from 7/28/16 until 8/6/16, revealed no appointment was scheduled for Resident #3 to the hospital for paracentesis. Physician order dated 7/29/16 indicated to arrange transportation for Resident #3 to the hospital emergency room (ER) for a paracentesis (procedure to drain fluid off the abdomen.) Physician order dated 8/2/16 indicated, make an appointment to hospital for paracentesis and notify nurse practitioner when Resident #3 transportation was arranged to hospital. On 8/23/16 at 10:50am, Nurse # 3 indicated the nurses were responsible for following up on the status of a resident who went to an appointment.	F 250	1) Interventions for affected resident: Resident #3 was taken to the Emergency Room to have a procedure preformed. The resident received successful medical care and needed transportation back to Randolph Rehab after hours. The resident's parents picked him up after our facility failed to pick him and took him home. They returned him to our facility the next morning after speaking with the Administrator on 8/26 about the transportation situation. 2) Interventions for residents identified as having the potential to be affected: No other residents were affected by this finding. However, the transportation needs after hours were immediately changed to include calling an outside transportation company and using the P-card (Visa) to pay for the ride to or from our facility. 3) Systematic Change: The Director of Nursing and Staff Development Coordinator, on Aug 26, 2016 in serviced nursing staff to include PRN and part time on the afterhours transportation policy to be used in situations like this one to avoid a resident having to sit in an emergency room or	9/25/16

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

Electronically Signed | 09/16/2016

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F 250	Continued From page 1 On 8/25/06 at 9:34 AM, the appointment scheduler indicated she had not scheduled Resident #3 for an appointment to the hospital and didn ' t recall the date Resident #3 went to the hospital. She indicated the transportation driver, came in and told her that he was taking Resident #3 the hospital for a paracentesis. The transportation driver was off duty at 5:00 PM. She had not scheduled any transportation back to the facility. On 8/25/16 at 9:53AM, via telephone the transportation driver indicated the appointment scheduler told him on 8/3/16 to take Resident #3 to the hospital emergency room and drop him off. He took Resident #3 to the hospital between 1:30pm-2:00 pm and provided him the transportation cell phone number. He told Resident #3 to call to be picked up. The transportation driver indicated he had not informed the facility he had dropped Resident #3 off. He indicated he turned off the transportation cell phone at 5:00pm and heard the messages from Resident #3 the next day. On 8/25/06 at 10:21 AM, Nurse Practitioner indicated the facility had a problem with getting Resident #3 to the hospital ER. She indicated he had an appointment that was canceled on 8/3/16 and the facility transported him to the hospital on that day. On 8/25/16 at 10:39AM, the appointment scheduler indicated she was not aware Resident #3 had been left at the hospital without transportation back to the facility until the next day. She reported it to the Director of Nursing (DON). On 8/25/16 at 12:10PM, DON indicated the facility had total responsibility to ensure transportation back from an appointment after hours. On 8/25/16 at 12:47PM, via telephone Nurse #11	F 250	doctor office. Further, new hires will be in serviced in orientation on the transportation policy. The Director of Nursing will review daily transports in Stand Up to ensure compliance for 4 weeks. 4) Monitoring of the change to sustain ongoing system compliance: Monthly for a minimum of three (3) months, the Director of Nursing will report the results of the audits for transportation to the Quality Assurance and Performance improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained and ongoing; and determine the need for further auditing beyond the three (3) months.	

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F 250	Continued From page 2 indicated the family of Resident #3 called at 9:00pm and said he had no transportation back to the facility and they were going to take him home to their house. Nurse #11 indicated she called the transportation driver and he said he was told leave the resident at the hospital. On 8/25/16 at 1:50Ppm, via telephone a family member of Resident #3 indicated they spoke with a nurse at facility on 8/3/16 at 8:30pm who said there was no transportation available back to the facility. On 8/25/16 at 1:58pm, via telephone Resident #3 indicated on 8/3/16 at 12:00pm, he was dropped at the ER and given the transportation cell phone number and told to call and he would be picked up. He indicated he began calling about 6:00pm and left voice mails. He indicated he called the facility at 8:00pm and there was no answer. He called family and friends to try to find a ride. Family arrived about 9:30pm and took him to their home. On 8/25/16 at 2:54pm, the DON indicated the facility discussed merging two appointment systems for one person to coordinate all appointments. Currently nurses made some appointments and the scheduler made other appointments.	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the	F 278		9/25/16

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F 278	Continued From page 3 assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to accurately access two (2) residents for oxygen use (Resident #5 and #6) and one (1) resident (Resident #7) for hospice service . Findings included: 1. Resident # 5 was admitted on 1/19/15 with the diagnoses of anemia, heart failure, and pulmonary disease. The most recent minimum (MDS) data set dated 8/11/16 revealed oxygen use was not coded. Review of the physician order dated 5/6/16, revealed to administer oxygen at 2 liters consistently. Review of the medication administration record for August 2016 revealed the nurses had	F 278	1) Interventions for affected resident: Residents #5 and #6 MDS assessments were modified on September 7 & September 9, 2016 to reflect that the each resident was using oxygen. Resident #7 MDS assessment was modified on 9/8 to reflect that they are hospice. 2) Interventions for residents identified as having the potential to be affected: On Aug 26 - Aug. 31, 2016, an audit was conducted by the MDS Supervisor to ensure current residents on oxygen and/or hospice were coded correctly. Three other residents need modifications of the MDS to reflect oxygen use and	

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F 278	Continued From page 4 documented oxygen use via nasal cannula on each shift. Review of the care plan initiated 4/17/16 and last updated 8/11/16, indicated in part, Respiratory risk due to oxygen delivery of 2 liters via nasal cannula due to chronic pulmonary disease. 2. Resident #6 was admitted on 5/22/15 with the diagnoses of anemia, heart failure and pulmonary disease. The most recent MDS dated 8/9/16 revealed oxygen use was not coded. Review of the care plan initiated on 5/17/16 and last updated on 8/9/16, indicated in part, Respiratory risk due to oxygen delivery of 2 liters via nasal cannula due to respiratory failure and congestive heart failure. On 8/23/16 at 2:14pm, MDS nurse indicated when a resident wore continuous oxygen the MDS was coded to reflect it. She indicated she reviewed the assessments, read nursing and progress notes, orders and conducted a bedside interview . Observation on 8/22/16 at 7:44pm, Resident #5 was observed wearing oxygen via nasal cannula. Observation on 8/22/16 at 7: 51pm, Resident #6 was observed wearing oxygen via nasal cannula. Observation on 8/23/16 at 2:27pm, Resident #5 and #6 were each observed wearing oxygen via nasal cannula. Observation revealed on 8/23/16 at 2:27pm, Resident # 5 and #6 had oxygen infusing via nasal cannula. During an interview on 8/25/16 at 3:15pm, Nurse #14 indicated Resident #5 and #6 wore continuous oxygen. Resident #6 had an order for continuous oxygen. She had not completed the August 2016 orders. During an interview on 8/25/16 at 3:45pm, Aide #2 indicated Resident #5 and #6 always wore	F 278	were corrected by the MDS Staff on 9/7 and 9/14. Two Resident assessments needed modification to reflect that resident on hospice benefits and were corrected by the MDS Staff on 9/8. 3) Systematic Change: The District Division MDS Director, on Aug 26, 2016 in serviced the MDS director on correct coding procedure to avoid future entry errors. On Aug. 29, 2016 the MDS director in serviced the 2 MDS coordinators and the one nurse who assists prn in MDS dept. regarding the RAI coding chapters three Section O, 00100 c and 00100k and case mix supportive documentation guidelines. The Staff Development Coordinator conducted an in-service on August 27, 2016 for full time, part time and casual nurses to ensure timely documentation and communication of resident's on oxygen and/or hospice services. They were also in serviced on clearly communicating in Point Click Care when a resident is placed on Hospice to ensure that MDS is made aware of the change The MDS Supervisor will review each MDS to ensure residents with an O2 requirement and/or Hospice is coded correctly before transmission to state. This will be documented on MDS Audit log for residents receiving oxygen and/or hospice and reviewed at the morning Clinical Meeting daily for four weeks starting August 29, 2016 and ending on September 23, 2016. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a	

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F 278	Continued From page 5 oxygen. During an interview on 8/25/16 at 4:08pm, Nurse #15 indicated Resident #5 and #6 wore continuous oxygen. During an interview on 8/25/16 at 7:19pm, Aide # 1 indicated Resident #5 and #6 wore continuous oxygen. During an interview on 8/25/16 at 7:36 pm, Nurse # 16 indicated Resident #5 and #6 wore continuous oxygen. 3. Resident #7 was admitted on 9/8/15 with the diagnoses of Alzheimer ' s dementia and cerebral vascular accident. Review of the MDS ' s dated 3/16/16 and 6/16/16 were not coded to reflect hospice. Review of the physician order dated 9/8/15 revealed " admit to hospice services with the diagnosis of Alzheimer ' s disease. " Record review of the care plan initiated 9/21/15 last updated 6/22/16, revealed Resident #7 chose to have death with dignity, no cardiopulmonary resuscitation (CPR) and hospice services. During an interview on 8/25/16 at 4:11pm, MDS nurse indicated Resident # 7 was a hospice patient. She indicated it was a data entry mistake. During interview on 8/25/16 at 4:25pm, Assistant Director of Nursing indicated Resident #7 had received hospice services for many months.	F 278	minimum of three (3) months, the MDS Supervisor will report the results of the audits for proper completion of the MDS and follow up on MDS with Oxygen and/or Hospice needs. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing, beyond the three (3) months period.	
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review pharmacy,	F 333	1. Interventions for affected resident:	9/25/16

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F 333	Continued From page 6 resident and staff and resident interviews the facility failed to administer medications of newly admitted residents for 3 of 3 sampled residents (Residents # 2, #10, #11.) Findings included: 1. Resident #2 was admitted on 7/11/16 with the diagnosis in part of respiratory failure, interstitial pulmonary fibrosis, diabetes mellitus, and asthma and depression. The minimum data set dated 7/11/16 (MDS) had entry data only. The admission nursing admission intake from dated 7/11/16 at 7:50pm, revealed Resided #2 was cognitively intact. Record review of the physician orders dated 7/11/16 revealed give omeprazole 40 milligram by mouth two times per day before meals, ipratropium-albuterol 0.5-2.5 milligram/3 ml (milliliters) solution take 3ml by nebulization 4 (four) times daily. Give levothyroxine 200 micrograms (mcg) by mouth daily and give prednisone 20 milligrams (mg) 2 tablets by mouth daily with breakfast. Give pirfenidone 267 mg 1 capsule three times daily. Give topiramate 25 mg by mouth two times per day. Give dicyclomine 20 mg by mouth every six hours. Give duloxetine60 mg by mouth every morning. Give insulin aspart 9 units subcutaneously four times a day with meals. Give estrogen 0.625mg tablet by mouth every morning. Give vitamin E 400 units by mouth two times a day. Give Vitamin D 1000 units by mouth every morning. Physician ordered dated 7/12/16 revealed to give novolog sliding scale insulin, 2 units for a finger stick blood glucose of 151-200. Review of the medication administration record (MAR) revealed the following medication administration was omitted on 7/12/16 at 6:00am ipratropium-albuterol 0.5-2.5 milligram/3 ML nebulizer and at 6:30am,levothyroxine 200 mcg, pirfenidone 267 mg, novolog 2 units for blood sugar of 179,omeprazole 40 mg. The 8:00am	F 333	Resident #2's orders were verified with the MD for accuracy. The DON checked on Aug 26, 2016 the med cart to ensure all ordered medication were available on the cart. The resident had no adverse outcome and discharged the next day. Resident #10's orders were verified with the MD for accuracy. The DON checked on Aug 26, 2016 the med cart to ensure all ordered medication were available on the cart. The resident had no adverse outcome and orders were verified and the resident discharged prior to further dosing of medication. 2. Interventions for residents identified as having the potential to be affected: On Aug 29, 2016, The Director of Nursing, Assistant Director of Nursing, and Nursing Supervisors audited all medication orders received over the past 7 days to ensure Medication was readily available in the building for administration. From 8/29 – 9/21, Licensed Nurses were re-educated by Director of Nursing or Assistant Director of Nursing on the proper procedure for ordering Medication, utilizing the pharmacy cabinet, and ordering from the back up pharmacy. Licensed Nurses were also re-educated on procedures for timely administration of medication and the procedure for contacting the MD and pharmacy when medication has not arrived in time for the ordered administration time. 3. Systematic Change: Newly hired Licensed Nurses will be educated during their orientation period by the facility Director of Nursing or Staff Development Coordinator on the proper	

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F 333	Continued From page 7 administration of prednisone 20 mg, topiramate 25 mg, vitamin E 400 units, estrogen 0.625 mg, Vitamin D 1000 units, dicyclomine 20 mg, duloxetine60 mg., insulin aspart 9 units at breakfast, 11:30am, Insulin aspart 2 units for blood sugar of 153 and at 12:00pm, dicyclomine 20 mg. During interview on 8/23/16 at 8:07pm Resident #2 indicated she arrived to the facility at 8:00pm and had not received any of her medication the next morning. During interview on 8/24/16 at 1:22pm, Nurse # 9 indicated Resident #2 arrived on 7/11/16 during the evening. New admission medications were faxed to the pharmacy and were scheduled to be delivered at night for the next day. The medications due at 6:00 am, 6:30 am and 8:00am should have been delivered during the night and administered on 7/12/16. During interview via telephone on 8/24/16 at 1:30pm, Nurse # 8 indicated Resident #2 arrived from the hospital that evening and stated she had received her evening medications at the hospital. She was unable to verify with the hospital, via telephone because the nurse had left for the day. During interview via telephone on 8/24/16 at 1:56pm, Nurse # 7 indicated she gave Resident#2 the stock medication at 8:00pm, the other medication had not arrived from the pharmacy. 2. Resident #10 was admitted on 8/23/16 with diagnoses in part, throat cancer and gastrostomy (a tube in the stomach). Record review of the physician order dated 8/23/16 revealed to give lansoprazole (a proton pump inhibitor to decrease the amount of acid produced in the stomach), 30 mg via gastrostomy tube one time a day. Record review of the medication administration record revealed omission of administration of	F 333	procedure for ordering Medication, utilizing the pharmacy cabinet, and ordering from the back up pharmacy. Licensed Nurses will also be educated on procedures for timely administration of medication and the procedure for contacting the MD and pharmacy when medication has not arrived in time for the ordered administration time. The Director of Nursing or Nursing Supervisors will audit 5 news orders daily to ensure medication is readily available for administration via pharmacy, medication cabinet, or back up pharmacy. Audits will be completed 5 days a week for 12 weeks. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report audit findings from Medication availability audit to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	

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F 333	Continued From page 8 lansoprazole on 8/24/16 at 6:30 am. During interview on 8/25/16 at 8:35 am, Nurse # 4 indicated she had not been given access to use the medication dispensing cabinet and didn ' t think to use it to obtain the lansoprazole. 3. Resident #11 was admitted on 8/23/16 with the diagnoses in part of diabetes mellitus, hypothyroidism and chronic obstructive pulmonary disease. Record review of the physician order revealed to administer levothyroxine 125 micrograms take 1 tablet before breakfast, glipizide 10 milligram tablet, take one tablet by mouth daily before breakfast and ipratropium-albuterol 0.5-2.5 milligram/3 milliliters solution take 3 ml by nebulization 4 (four) times daily. Review of the medication administration record dated 8/24/16, revealed the omission of administration of levothyroxine 125 micrograms at 06:30AM. The omission of the administration of the medication ipratropium-albuterol 0.5-2.5mg/3 milliliter at 6:00AM and glipizide 10 milligrams tablet before breakfast. During interview via telephone on 8/24/16 at 4:32pm, pharmacy manager indicated medications were delivered at 1:00am for new admissions and controlled medications. The courier left the pharmacy at 10:30 am and 2:00pm for regular deliveries. The facility had a medication dispensing cabinet and a local back up pharmacy. During telephone interview on 8/24/16 at 6:52pm Nurse #4 indicated she had not administered the medications at 6:00am or 6:30am because they had not arrived from the pharmacy.	F 333		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		9/25/16

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F 425	Continued From page 9 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review pharmacy and staff interview the facility failed to provide medications for administration for 1 of 3 sampled residents (Resident #2.) Findings included: Resident #2 was admitted on 7/11/16, with the diagnosis in part, of respiratory failure, interstitial pulmonary fibrosis, diabetes mellitus, and asthma and depression. Record review of the fax stamp revealed on 7/12/16 at 12:16am, the facility faxed the pharmacy Resident #2 medication orders. Review of the medication administration record dated 7/12/16 revealed the follow medication were not administered. ipratropium-albuterol	F 425	1. Interventions for affected resident Resident #2's orders were verified with the MD for accuracy. The DON checked on Aug 26, 2016 the med cart to ensure all ordered medication were available on the cart. The resident had no adverse outcome and discharged the next day. 2. Interventions for residents identified as having the potential to be affected: The Director of Nursing and Nursing Supervisors on Aug 29, 2016 audited the med carts and medication dispensing cabinets to ensure all medication ordered was readily available. From 8/29- 9/21, Licensed Nurses were	

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F 425	Continued From page 10 0.5-2.5 milligram/3 ml (milliliter)via a nebulizer, levothyroxine 200 mcg(micrograms), pirfenidone 267 mg (milligrams) , insulin aspart 2 units for blood sugar of 179 at 6:30am, omeprazole 40 mg, prednisone 20 mg, topiramate 25 mg, vitamin E 400 units, estrogen 0.625 mg, Vitamin D 1000 units, dicyclomine 20 mg, duloxetine60 mg ,insulin aspart 9 units at breakfast, insulin aspart 2 units for blood sugar of 153 at 11:30am, and dicyclomine 20 mg. Review of the pharmacy shipment summary revealed the medications were shipped on 7/12/16 no time, via a courier. The medications were picked up from the pharmacy at 7/12/16 at 2:45pm and delivered to the facility at 5:00pm. Nurse # 8 signed for the delivery. During an interview on 8/24/16 at 1:56 pm, Nurse #7 indicated she remembered Resident #2. She indicated she was told at report Resident #2 medications had not arrived. During interview on 8/24/16 at 1:30pm, Nurse # 8 indicated she doesn ' t remember Resident #2. There was a different medication dispensing cabinet at that time. During interview via telephone on 8/24/16 at 4:32pm, pharmacy manager indicated medications were delivered at 1:00am for new admissions and controlled medications. The courier left the pharmacy at 10:30 am and 2:00pm for regular deliveries. The facility had a medication dispensing cabinet and a local back up pharmacy. During interview on 8/24/16 at 5:15pm, the Director of Nursing indicated when a resident arrived late in the evening. The medications were faxed for the late pharmacy run. She had no further comment. During a telephone interview on 8/25/16 at 9:05am, Nurse # 5 she indicated she didn ' t	F 425	re-educated by Director of Nursing or Assistant Director of Nursing on the proper procedure for ordering Medication, utilizing the pharmacy cabinet, and ordering from the back up pharmacy. Licensed Nurses were also re-educated on procedures for timely administration of medication and the procedure for contacting the MD and pharmacy when medication has not arrived in time for the ordered administration time. 3. Systematic Change: Newly hired Licensed Nurses will be educated during their orientation period by the facility Director of Nursing or Staff Development Coordinator on the proper procedure for ordering Medication, utilizing the pharmacy cabinet, and ordering from the back up pharmacy. Licensed Nurses will also be educated on procedures for timely administration of medication and the procedure for contacting the MD and pharmacy when medication has not arrived in time for the ordered administration time. The Director of Nursing or Nursing Supervisors will audit medication carts and the medication dispense cabinet to ensure medication is readily available for administration via pharmacy, medication cabinet, or back up pharmacy. Audits will be completed 2 times a week for 12 weeks. 4. Monitoring of the change to sustain system compliance ongoing: Monthly for a minimum of three (3) months, the Director of Nursing will report audit findings from Medication availability audit to the Quality Assurance and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345155	A. BUILDING _____ B. WING _____	C 08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RANDOLPH HEALTH AND REHABILITATION CENTER	230 EAST PRESNELL STREET ASHEBORO, NC 27203

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F 425	Continued From page 11 remember Resident #2. She was unable to recall if she ordered the medications. She indicated when a new resident arrived she notified the physician and had the orders approved. She faxed the order to the pharmacy. Medication was also in the medication dispensing cabinet. There was also the option to get " stat " medication from the local pharmacy.	F 425	Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three (3) months.	