STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING _____ B. WING _____	C 05/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHABILITATION CENTER	300 BLAKE BOULEVARD PINEHURST, NC 28374

(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 000	INITIAL COMMENTS A complaint investigation and revisit survey were conducted on 5/11/21. Event ID# 7LH211. 1 of the 5 complaint allegations was substantiated resulting in a deficiency.	F 000		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 732		5/19/21

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

Electronically Signed | 05/18/2021

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F 732	Continued From page 1 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation of the facility ' s required posted daily Nurse Staffing forms and staff interview, the facility failed to post the Nurse Staffing form every other weekend from 5/1/20 through 5/9/21 in addition to 5/10/21. The findings included: An observation of the posted daily Nurse Staffing form on 5/11/21 at 6:40 AM revealed the posted forms at 2 of 2 nursing stations were dated 5/7/21. During an interview with Nursing Supervisor #1 on 5/11/21 at 10:45 AM he stated that he was responsible for posting the daily Nurse Staffing forms every weekday (Monday through Friday). He reported that he forgot to post the form yesterday (Monday), 5/10/21, as he was working on the floor. He indicated he was unsure who posted the forms on the weekends. During an interview with the Director of Nursing (DON) on 5/11/21 at 11:50 AM she verified that Nursing Supervisor #1 was responsible for posting the daily Nurse Staffing forms every weekday. She reported that the Weekend Nurse Supervisor posted the Nurse Staffing form every other weekend. She explained that the facility only had 1 Weekend Nurse Supervisor and she worked every other weekend. She revealed that	F 732	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F732 1. Corrective action for resident(s) affected by the alleged deficient practice: On 05/11/2021, The Director of Nurses ensured that the daily nurse staffing postings have been posted and the recent completed postings are stored in a manner to allow for easy review upon request. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: There were no residents affected by this deficient practice. On 05/11/2021, The Director of Nurses	

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F 732	Continued From page 2 she had not known who posted the daily Nurse Staffing form on the weekends that the facility ' s only Weekend Nurse Supervisor was not working. The DON suggested speaking with the Nurse Secretary as she was responsible for filling out the daily Nurse Staffing forms. An interview was conducted with the Nurse Secretary on 5/11/21 at 12:40 PM. She stated that she filled out the daily Nurse Staffing forms every weekday and every other weekend. She indicated that Nursing Supervisor #1 posted the forms every weekday. When asked who posted the daily Nurse Staffing forms on the weekends she explained that the facility had a Weekend Nurse Supervisor who worked every other weekend and that this Weekend Nurse Supervisor filled out and posted the forms on the weekends that she worked. The Nurse Secretary further explained that the Weekend Nurse Supervisor used to work every weekend, but about a year ago she switched from every weekend to every other weekend. The Nurse Secretary revealed that she was aware the daily Nurse Staffing forms were not posted every other weekend. She indicated that she filled them out, kept them in her office, and updated them when she came into work on Monday with any staff changes that occurred over the weekend. When the Nurse Secretary was asked if the DON, Administrator, and/or Nursing Supervisor #1 were aware that the daily Nurse Staffing form was not posted as required every other weekend she stated that the DON was aware. A follow up interview was conducted with Nursing Supervisor #1 on 5/11/21 at 12:45 PM. He stated that he had not noticed that the daily Nurse Staffing form was not posted every other	F 732	ensured that the daily nurse staffing postings have been posted and the completed postings are stored in a manner to allow for easy review upon request. On 05/14/2021, the staffing sheets were reviewed by the Director of Nurses and the Administrator from 05/11/2021 through 05/18/2021 to ensure that daily nurse staffing was posted for each day as required. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: The Administrator or designee will be responsible for ensuring the daily nurse staff posting is posted daily according to the requirements. The daily posting will be viewed as part of the daily stand up meeting. On 05/12/2021, the Quality Assurance Clinical Nurse Consultant completed education on Daily Nursing Staff Posting Requirements for the following staff, the Director of Nurses, Registered Nurse Supervisor, Scheduler, and the Support Nurse with emphasis on the following objectives (See the Daily Nursing Staff posting Requirements Education) Objectives: " To identify the regulatory requirement of F 732 for Posted Nursing Staff Information " To monitor that the requirement for F732 is met daily and includes the data	

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F 732	Continued From page 3 weekend. He reported that when he came to work every weekday morning he took the previous posting out and put the new one in and that he had not paid attention to the date on the previous posting. A follow up interview was conducted with the DON on 5/11/21 at 1:14 PM. She stated that she had not realized that the daily Nurse Staffing form was not posted every other weekend. She stated that her expectation was for the daily Nurse Staffing form to be posted each day as required by the regulation. During a follow up interview with the Nurse Secretary on 5/11/21 at 1:35 PM she revealed that the Weekend Nurse Supervisor started working every other weekend beginning in May 2020. She confirmed that it had been over 1 year that the daily Nurse Staffing form was not posted every other weekend.	F 732	requirements, posting requirements, Public access to posted nurse staffing data, and Facility data retention requirements. On 05/13/2021, the Director of Nurses completed education with the Administrator, RN Weekend Supervisor, and the Weekend Support Nurse on the Daily Nursing Staff Posting Requirements with emphasis on the same objectives listed above. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory/requirements. The Administrator, Director of Nurses, or designee will monitor compliance utilizing the F732 Quality Assurance Tool weekly for daily nursing staff postings x 2 weeks then monthly x 3 months they will review to ensure there is a daily posting form for each day. Reports will be presented to the weekly Quality Assurance committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager.	

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F 732	Continued From page 4	F 732	Date of Compliance: 05/18/2021	
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:	F 755		5/19/21

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F 755	Continued From page 5 Based on record review, observation, and interviews with resident, Medical Director, and staff, the facility failed to acquire routine medications for administration resulting in the failure to administer medications as ordered by the physician for 2 of 3 residents (Residents #1 and #2) reviewed for the provision of pharmaceutical services to meet residents' needs. The findings included: 1. Resident #2 was admitted to the facility on 8/31/2021 with diagnoses that included hemiplegia and hemiparesis secondary to cerebral infarct (stroke). Resident #2's most recent Minimum Data Set (MDS) dated 4/22/2021 indicated the resident was mildly cognitively impaired and required extensive assistance for activities of daily living and was dependent in personal hygiene and toileting. A review of Resident #2's May 2021 physician's order summary revealed medication orders for Lamisil (an antifungal) 250 milligrams (mg) to be given by mouth every morning for dermatitis, Allegra (an antihistamine) 180 mg by mouth daily to be given in the morning for pruritis, and Colchicine 0.6 mg by mouth daily for gout. Resident #2's Medication Administration Record (MAR) for the month of May 2021 revealed the resident was documented as not having received Allegra or Lamisil on Saturday May 8th or Sunday May 9th but received the medications on Monday May 10th.	F 755	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F755 1. Corrective action for resident(s) affected by the alleged deficient practice: On 05/12/2021, The Director of Nurses ensured that Resident #1□s medications have been reconciled and were available to administer. Medications that were not received from the pharmacy were available in the emergency medication kit or obtained from the facility back up pharmacy. All medications were received on 05/11/2021 □ 05/13/2021 for resident #1 and are now available in the medication cart. The physician was notified of the medication not being administered because they were not available. On 05/12/2021, The Director of Nurses ensured that Resident #2□s medications have been reconciled and were available to administer. Medications that were not received from the pharmacy were available in the emergency medication kit or obtained from the facility back up pharmacy. All medications were received	

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F 755	Continued From page 6 On 5/11/2021 at 8:19am during a medication administration observation, Nurse #1 stated she could not administer all of Resident #2's scheduled medications because some of them were not in stock. She further stated the resident's Allegra, Lamisil, Colchicine were not on the medication cart. Nurse #1 was observed entering an order for the three medications from pharmacy. When asked, Nurse #1 stated when a medication was getting low, they could order it from the pharmacy electronically. She also stated the pharmacy typically made deliveries once daily in the late afternoon or evening hours. On 5/11/2021 at 12:47pm an interview was conducted with Medication Aide #1. She stated she worked the medication cart on Saturday May 8, 2021 and she administered Resident #2's medications on that day. She revealed Resident #2 was ordered Allegra and Lamisil, but these medications were not on the cart so she had not administered them. She stated she thought she ordered both medications from the pharmacy the facility utilized, but she had not worked the medication cart that often and was not as familiar with the process as some of the other staff. A telephone interview was conducted with Nurse #2 on 5/11/2021 at 1:15pm. She stated she worked the medication cart on Sunday May 9, 2021 and administered Resident #2's medications on that day. She revealed Resident #2 was ordered Allegra and the Lamisil, but these medications were not on the medication cart and she had not administered them. She stated she had not recalled ordering either medication from the pharmacy the facility utilized because she knew the resident had recently had some tests completed and she thought the medications may	F 755	on 05/11/2021 □ 05/13/2021 for resident #2 and are now available in the medication cart. The physician was notified of the medication not being administered because they were not available. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: All residents who receive medications have the potential of being affected by the alleged deficient practice. On 05/12/2021, the Director of Nurses, Licensed Practical Nurse Support Nurse (LPN), Registered Nurse Supervisor (RN), and the Quality Assurance Nurse Consultant (QA) initiated an audit of 100% of the Medication Administration for the last 7 days for all current residents. The audit consisted of a review of the Electronic Medical Administration Records (EMAR) notes to identify any medications that were not administered due to not being available. The audit identified 29 residents who had medications that were not administered. The pharmacy was contacted for any medications that were identified as not being available and the medications were delivered to the facility between 05/11/2021 □ 05/13/2021 for the residents who were affected. Medications that were not received from the pharmacy were available in the emergency medication kit or obtained from the facility back up pharmacy.	

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F 755	Continued From page 7 have been discontinued. On 5/11/2021 at 9:30am and interview was conducted with Nursing Supervisor #1. He stated he was working the medication cart on Monday May 10, 2021 and was training Nursing Supervisor #2. He explained that it was Nursing Supervisor #2's first day on a medication cart. He stated he gave the Allegra and the Lamisil to Resident #2 on Monday May 10, 2021. When asked why the medications were not found on the cart Tuesday May 11th, 2021 he stated the nurses may not have known where to look for the medications. He stated the Allegra was an over the counter medication (OTC) and could be found in the facility's stock. The Lamisil was kept on the treatment cart and the nurses may not have known to go looking for it on the treatment cart. When asked to produce the Allegra and the Lamisil for writer on 5/11/2021, Nursing Supervisor #1 was unable to find the Allegra or the Lamisil in the facility's stock of medications. A telephone interview was conducted on 5/11/2021 at 10:57am with the treatment nurse who worked on Saturday May 8th and Sunday May 9th. She stated oral medications were not kept on the treatment cart and she had not seen Lamisil on the treatment cart over the weekend. She stated she had not given Resident #2 Lamisil on 5/8/2021 or 5/9/2021. An interview was conducted with the Nurse Secretary on 5/11/2021 at 1:00pm she stated she was responsible for ordering OTC medications. She further stated she checked the facility inventory once weekly on either Monday or Tuesday. She typically placed an order on Thursday and it usually arrived on Monday or	F 755	On 05/11/2021, the director of Nurses notified the Medical Director of the medications that were not administered and the steps that were taken to prevent future occurrences of medications not being available. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: After discussion with the nurses and medication aides to determine root cause, we determined that staff lacked knowledge of all resources available to obtain medications that were not available, didn□t always have the time to obtain medications from the facility back up pharmacy, or didn□t have transportation to obtain medications that needed to be administered. On 05/12/2021, The QA Nurse consultant worked with the pharmacy to secure courier service for the backup pharmacy services. On 05/14/2021, the pharmacy was able to confirm that the facility has a backup pharmacy service courier in place for the facility that will assist with obtaining medications from the backup pharmacy if medications are not available in the facility. On 05/13/2021, the facility staff were also educated to contact the Director of Nurses or the on-call Nurse to communicate any obstacles that would prevent the staff from being able to administer medications as ordered. The Director of Nurses or designee will add review of the EMAR	

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F 755	Continued From page 8 Tuesday of the following week. When asked about Allegra, she stated that was not an OTC medication she ordered. She stated Allegra was ordered through the pharmacy by the nurses. A second interview was conducted with Nurse #1 on 5/11/2021 at 1:17pm, she stated it was difficult to determine which medications were ordered from the pharmacy and which ones were part of the facility's OTC stocked medication. She further stated the process had recently changed and it was confusing. An interview was conducted with the facility's medical director on 5/11/2021 at 11:00am. He stated he expected residents to receive medications per physician's orders and for the facility to ensure procedures were in place for acquiring medications needed for administration. On 5/11/2021 at 11:47am an interview was conducted with the DON. When asked, she stated the MARs were not reviewed monthly for inconsistencies. She was not aware there was a problem acquiring medications in a timely manner and she felt this problem needed to be corrected. 2. Resident #1 was admitted to the facility on 4/9/21 with diagnoses that included Urinary Tract Infection (UTI), hyperlipidemia, gastroesophageal reflux disease (GERD), atrial fibrillation, Chronic Obstructive Pulmonary Disease (COPD), low back pain, and osteoarthritis. The physician's orders on admission (4/9/21) for Resident #1 included, in part, the following: - Cephalexin (antibiotic) 500 milligrams (mg)	F 755	progress notes to their daily checklist to identify any residents who didn□t have medications available to be administered. On 05/13/2021, the Director of Nurses, RN Supervisor, and the LPN Support Nurse initiated education on Medication Availability for all Licensed Nurses (RN□s and LPN□s), Medication Aides, Full Time, Part Time, PRN, and Agency Staff on the following education: " The learner will understand the importance of ensuring that medications are always available to be given to the resident as ordered by the Physician. " The learner will understand the steps necessary to obtain medications from the McNeill□s Long-Term Care Pharmacy during business hours and after business hours for all situations. All education for current staff will be completed by 05/18/2021. As of 05/18/2021 at 5 PM, any employee who has not received this training will not be allowed to work until the training has been completed. This includes all Licensed Nurses and Medication Aides, full time, part time, agency staff, and PRN staff. This in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory/requirements.	

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F 755	Continued From page 9 three times daily for UTI (start date 4/9/21) - Albuterol Sulfate inhalation aerosol solution 108 (90 base) micrograms (mcg)/actuation (act) 2 puff inhale every 4 hours for shortness of breath/wheezing (start date 4/9/21) - Diclofenac Sodium gel (anti-inflammatory gel) 1% apply 2 grams transdermally four times a day for pain (start date 4/9/21) - Capsaicin-Menthol gel (topical analgesic gel) 0.025-10% apply to bilateral (both) legs topically once daily for pain (start date 4/10/21) - Clopidogrel Bisulfate (anti-platelet) 75 mg once daily for atrial fibrillation (start date 4/10/21) - Omeprazole delayed release 20 mg once daily for GERD/heartburn (start date 4/10/21) - Evolocumab Solution prefilled syringe 140 mg/ml inject 1 milliliter (ml) subcutaneously at bedtime every 14 days for hyperlipidemia (start date 4/16/21) The April 2021 Medication Administration Record (MAR) and electronic MAR (eMAR) notes revealed the following medications were not administered as ordered due to the facility not acquiring the medication promptly upon Resident #1's admission to the facility (4/9/21 admission): - 2 doses of Capsaicin-Menthol gel (4/10/21 and 4/11/21) - 1 dose of Clopidogrel Bisulfate (4/10/21) - 1 dose of Omeprazole (4/10/21) - 1 dose of Evolocumab injection (4/16/21) - 2 doses of Cephalexin (4/13/21) - 8 doses of Diclofenac Sodium gel (4/9/21, 4/10/21, 4/11/21) - 6 doses of Albuterol Sulfate (4/9/21 and 4/10/21) The admission Minimum Data Set (MDS) assessment dated 4/16/21 indicated Resident #1's cognition was fully intact. She had no	F 755	The Director of Nurses or designee will complete an ongoing audit weekly to review 100% of the EMAR progress. The audit will include review of the EMAR progress notes to identify any residents who have medications that have not been administered due to not being available. The Director of Nurses, or designee will monitor compliance utilizing the Medication Availability Audit Tool weekly x 4 weeks then monthly x 3 months. The audit will review EMAR progress notes to identify any residents that have medications that have not been administered due to not being available. Reports will be presented to the weekly Quality Assurance committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 05/18/2021	

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PINEHURST HEALTHCARE & REHABILITATION CENTER	300 BLAKE BOULEVARD PINEHURST, NC 28374

(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 755	Continued From page 10	F 755		

behaviors and no rejection of care.

An interview was conducted with Resident #1 on 5/11/21 at 9:45 AM. She stated that when she was initially admitted to the facility some of her medications were not administered for a couple of days. She indicated that staff, unable to recall whom, informed her all of the medications had not yet been received from the pharmacy.

An interview was conducted with the Director of Nursing (DON) on 5/11/21 at 10:02 AM. She stated that Nursing Supervisor #1 was responsible for sending the physician's orders for medications for newly admitted residents to the pharmacy.

An interview was conducted with Nursing Supervisor #1 on 5/11/21 at 10:45 AM. He confirmed he sent Resident #1 ' s medication orders to the pharmacy on the date of her admission (4/9/21). He indicated that Resident #1 was admitted around 2:00 PM. He reported that the pharmacy delivered medications once per day and that this delivery was normally sometime after 7:00 PM. He stated that medications for new admissions were most often received the evening of the admission. Nursing Supervisor #1 indicated that if the medications were not received by the following morning the nursing staff assigned to the resident were to contact the pharmacy to inquire about the medication and if the medications were not available that they were then to inform their nurse supervisor or the DON. He explained that if the medications were not available from the facility's regular pharmacy that the medications could be obtained stat (without delay) from a pharmacy that was in close proximity to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 755	Continued From page 11	F 755		

A review of the staff schedules, MARs, and nursing eMAR notes for Resident #1 indicated Nurse #3 was assigned to the resident on dates that medications were not administered as ordered due to the medicaions not being acquired from the pharmacy (4/9/21, 4/10/21, 4/11/21, and 4/16/21).

A phone interview was conducted with Nurse #3 on 5/11/21 at 12:28 PM. The April 2021 MAR and eMAR notes that revealed multiple doses of medications were not administered to Resident #1 upon admission to the facility due to the medications not being acquired from the pharmacy were reviewed with Nurse #3. Nurse #3 stated that Nursing Supervisor #1 sent the orders to the pharmacy for newly admitted residents. She stated that if the medication was not in stock at the facility that she just wrote a note that it was not available and/or that it was on order. She revealed that she had not followed up with the pharmacy to see when Resident #1's medications would be received at the facility.

An interview was conducted with the facility ' s Medical Director on 5/11/21 at 11:00 AM. He stated that he expected medications to be administered as ordered and for the facility to ensure procedures were in place for acquiring medications needed for administration.

During a follow up interview with the DON on 5/11/21 at 1:14 PM she stated that it was her expectation for medications to be acquired from the pharmacy and administered as ordered. When asked if there was a monitoring system in place for routinely reviewing the MARs, she revealed there was no system in place. The DON

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F 755	Continued From page 12 further revealed she was not aware there was a problem acquiring medications in a timely manner. She stated that this was a problem that needed to be corrected.	F 755		