

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175401		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/16/2026	
NAME OF PROVIDER OR SUPPLIER BONNER SPRINGS NURSING & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 520 E MORSE STREET , BONNER SPRINGS, Kansas, 66012			
(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
F0000	INITIAL COMMENTS The following citations represent the findings of complaint investigations 3006097, 2799218, 2795541, 2722966, and 2686784. The census was 37. The sample included 5 residents.			F0000			
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);			F0584			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0584 SS = E	Continued from page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, and record review, the facility failed to provide a clean, home-like environment for the residents who resided in the facility. Findings included: - On 06/16/2026 at 08:00 AM, during the facility walk through revealed Resident (R) 3's and R4's rooms had brown sticky stains on the floors. The West Hall smelled strongly of urine. with a stronger odor next to R2's room, which spread down the hallway. A Personal Protective Equipment (PPE) cart was placed in a cubby hole in the West Hall; the cart had a blue foam positioner on top of the cart, and on the floor beside the cart. The dining room had dried spilled stains throughout the dining room area. On the East Hall, R5's sink had dark brown rings on the outside of the sink. A hopper on the East Hall had brown standing water inside the hopper with brown substances floating in the water. The "Grievance Log" dated 02/21/2026 and 02/22/2026 documented "multiple families" complained that the floors were dirty and the facility had a smell. On 06/16/2026 at 02:10 PM, Administrative Nurse D stated she did not have family members complain about the smell of the facility or the cleanliness of the facility. She stated she did have an outside provider come to her about the smell and the cleanliness of a resident's room. She stated the specific rooms were deep cleaned. She stated the facility's expectations were the sinks, floors and rooms would be clean and the facility would not smell of urine. On 06/16/2026 at 03:00 PM, Administrative Staff A stated the facility had specific rooms on the West Hall that were known to have odors. She stated the			F0584			

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F0584 SS = E	Continued from page 2 expectation that all residents' rooms would be clean and without a urine smell.	F0584					
F0636 SS = D	The facility's "Quality of Life-Home Like Environment" policy dated 10/21 documented residents were provided with a safe, clean, comfortable, and homelike environment and encouraged to use their personal belongings to the extent possible. Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit.	F0636					

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F0636 SS = D	Continued from page 3 (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii) Not less than once every 12 months. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review, the facility failed to complete the "Care Area Assessment" (CAA) analysis of findings, related to a "Comprehensive Minimum Data Set" (MDS), for Residents (R) 1, in order to address the underlying cause, risk factors, and other contributing factors to ensure the resident received care based on their individual needs. Findings included: - R1 was admitted to the facility on 04/29/2026. The "Admission Minimum Data Set (MDS)" dated 05/12/2026 triggered the CAA for functional abilities (self-care mobility), urinary incontinence, indwelling catheter, pressure ulcer, pain, falls, communication, and psychotropic drug use. All triggered CAA had	F0636					

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F0636 SS = D	Continued from page 4 been completed on 06/05/2026, which was 24 days past due. On 06/16/2026 at 02:10 PM, Administrative Nurse D stated the CAA should be completed within the allotted timetable. Administrative Nurse D stated R1's CAA should have directed the person-centered care plan. The facility's "Comprehensive Assessments and the Care Delivery Process" policy last revised 12/2016 documented comprehensive assessments would be conducted to assist in the development of the person-centered care plans. Comprehensive assessments, care planning, and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions.	F0636					
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline	F0655					

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F0655 SS = D	Continued from page 5 care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review, the facility failed to develop a person-centered baseline care plan for Resident (R) 1, which included pain management. Findings included: - R1's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of nerve pain and herpes zoster (shingles- infection characterized by painful skin eruptions following the route of a nerve). The "Admission Minimum Data Set (MDS)" dated 05/12/2026 documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R1 had received opioid medication during the observation period. The MDS documented R1 received pain medication and had not received non-medication interventions during the observation period. The MDS documented R1 had reported frequent pain, occasionally had difficulty sleeping, and limited her day-to-day activities during the observation period related to pain. The MDS lacked a numerical rating for pain intensity for R1.	F0655					

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F0655 SS = D	Continued from page 6 R1's "Pain Care Area Assessment (CAA)", dated 06/05/2026 documented she triggered for frequent pain. Review of R1's EMR under the "Assessment" tab lacked a "Baseline Care Plan." The facility was unable to provide a "Baseline Care Plan" for R1 on 06/16/2026 as requested. (R1 was admitted to the facility on 04/29/2026). Review of R1's EMR under the "Care Plan" tab revealed a care plan that only addressed R1's code status as Full Code, dated 04/29/2026. R1's EMR under the "Orders" tab revealed the following physician orders: Oxycodone (opioid) hci oral tablet five milligrams (mg) give one tablet by mouth every six hours as needed for pain dated 04/29/2026. Tramadol (opioid) hcl oral tablet 50 mg give one tablet by mouth every six hours as needed for pain. Do not exceed 400mg daily, dated 04/29/2026. Tylenol (pain reliever) oral tablet 325 mg give two tablets by mouth every six hours as needed for pain, dated 05/02/2026. On 06/16/26 at 09:30 AM, R1 lay on her bed in the lowest position. R1 was covered with a blanket to her chest area as she watched TV. R1 stated she had not received her opioid pain medication a few weeks back. R1 stated the facility was unable to administer her pain medication that relieved the shingles pain in her right ear. R1 stated she had been in pain for two days, waiting for her pain medication. On 06/16/26 at 02:10 PM, Administrative Nurse D stated the baseline care plans should be completed after the resident's admission under the "Assessment" tab. Administrative Nurse D stated she was unable to locate R1's baseline care plan under the assessment tab. The facility's "Baseline Care Plan" policy last revised 12/2016 documented a baseline plan of care to meet the resident's immediate needs would be developed for each resident within forty-eight (48) hours of admission.			F0655			

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F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by:	F0656					

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F0656 SS = D	Continued from page 8 Based on interviews, observation, and record review, the facility failed to develop a person-centered comprehensive care plan for Resident (R) 1, which included pain management. Findings included: - R1 was admitted on 04/29/2026. R1's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of nerve pain and herpes zoster (shingles- infection characterized by painful skin eruptions following the route of a nerve). The "Admission Minimum Data Set (MDS)" dated 05/12/2026 documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R1 had received opioid medication during the observation period. The MDS documented R1 received pain medication and did not receive non-medication interventions during the observation period. The MDS documented R1 had reported frequent pain, occasionally had difficulty sleeping, and limited her day-to-day activities during the observation period related to pain. The MDS lacked a numerical rating for pain intensity for R1. R1's "Pain Care Area Assessment (CAA)", dated 06/05/2026 documented she triggered for frequent pain. R1' "Comprehensive Care Plan," documented the following interventions: 04/29/2026- Code status: Full code. The comprehensive care plan lacked any direction to nursing staff for pain management for R1. R1 was admitted to the facility for 47 days. R1's EMR under the "Orders" tab revealed the following physician orders: Oxycodone (opioid) hci oral tablet five milligrams (mg) give one tablet by mouth every six hours as needed for pain dated 04/29/2026. Tramadol (opioid) hcl oral tablet 50 mg give one tablet by mouth every six hours as needed for pain. Do not exceed 400mg daily, dated 04/29/2026. Tylenol (pain reliever) oral tablet 325mg	F0656					

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F0656 SS = D	Continued from page 9 (Acetaminophen) give two tablets by mouth every six hours as needed for pain dated 05/02/2026. On 06/16/2026 at 09:30 AM, R1 laid on her bed in the lowest position. R1 was covered with a blanket to her chest area as she watched TV. R1 stated she had not received her opioid pain medication a few weeks back. R1 stated the facility was unable to administer her pain medication that relieved the shingles pain in her right ear. R1 stated she had been in pain for two days, waiting for her pain medication. On 06/16/2026 at 02:10 PM, Administrative Nurse D stated the comprehensive care plans should be completed after the resident's admission and the completion of the MDS. The facility's "Comprehensive Assessments and the Care Delivery Process" policy, last revised 12/2016 documented comprehensive assessments would be conducted to assist in the development of the person-centered care plans. Comprehensive assessments, care planning, and the care delivery process involve collecting and analyzing information, choosing and initiating interventions, and then monitoring results and adjusting interventions.			F0656			
F0697 SS = D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, observation, and record review, the facility failed to ensure staff provided effective pain management as ordered for Resident (R) 1, who received a as needed opioid (a class of medication used to treat pain). Findings included: - R1's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of nerve pain and herpes zoster (shingles- infection characterized by painful skin eruptions following the route of a nerve).			F0697			

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F0697 SS = D	Continued from page 10 The "Admission Minimum Data Set (MDS)" dated 05/12/2026 documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R1 had received opioid medication during the observation period. The MDS documented R1 received pain medication and had not received non-medication interventions during the observation period. The MDS documented R1 had reported frequent pain, occasionally had difficulty sleeping, and limited her day-to-day activities during the observation period related to pain. The MDS lacked a numerical rating for pain intensity for R1. R1's "Pain Care Area Assessment (CAA)", dated 06/05/2026 documented she triggered for frequent pain. R1's "Care Plan," documented the following interventions: 04/29/2026- Code status: Full code. R1's "Care Plan" lacked any interventions for pain management. R1's EMR under the "Orders" tab revealed the following physician orders: Oxycodone (opioid) hci oral tablet five milligrams (mg) give one tablet by mouth every six hours as needed for pain dated 04/29/26. Tramadol (opioid) hcl oral tablet 50 mg give one tablet by mouth every six hours as needed for pain. Do not exceed 400 mg daily, dated 04/29/2026. Tylenol (pain reliever) oral tablet 325mg (Acetaminophen) give two tablets by mouth every six hours as needed for pain dated 05/02/2026. Review of R1's Medication Administration Record (MAR)" and the "Controlled Drug Receipt/Record/Disposition Form" provided by the facility reviewed from 04/29/2026 to 06/15/2026 (47 days) revealed R1 had received at least an oxycodone daily with the exception for the following dates 06/07/2026, 06/08/2026, and 06/09/2026. The controlled drug receipt/record/disposition record form dated 05/21/2026 the last dose of oxycodone that was administered was dated 06/06/26. The next sheet dated 06/09/2026 was the date the medication was delivered from the pharmacy. On 06/16/2026 at 09:30 AM, R1 laid on her bed in			F0697			

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F0697 SS = D	Continued from page 11 the lowest position. R1 was covered with a blanket to her chest area as she watched TV. R1 stated she had not received her opioid pain medication a few weeks back. R1 stated the facility was unable to administer her pain medication that relieved the shingle pain in her right ear. R1 stated she had been in pain for the two days, waiting for her pain medication. On 06/16/2026 at 12:51 PM, Licensed Nurse (LN) G stated several residents that received controlled pain medication had been without their medication. LN G stated the medical director only provided the facility with a handwritten prescription for the recording of their controlled medication on the days he made rounds at the facility. LN G stated she was attempting to eliminate that by tracking the as needed use and when the scheduled medication needed to be reordered. On 06/16/2026 at 02:10 PM, Administrative Nurse D stated there had been a few residents that had run out of their pain medications. Administrative Nurse D stated the facility was trying to work with the medical director to shorten the time the pharmacy received the prescription from the physician reordering to being filled by the pharmacy, and the facility received the medication. The facility's "Pain Assessment and Management" policy last revised 03/2020 documented the purpose of this procedure is to help the staff identify pain in the resident and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain.			F0697			
F0755 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(f). 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.			F0755			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175401		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/16/2026	
NAME OF PROVIDER OR SUPPLIER BONNER SPRINGS NURSING & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 520 E MORSE STREET , BONNER SPRINGS, Kansas, 66012			
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F0755 SS = D	Continued from page 12 §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 interviews, observation, and record review, the facility failed to ensure the accurate reconciliation of controlled drugs administered to the controlled drug receipt/record/disposition form for Resident (R) 1, who received a as needed opioid (a class of medication used to treat pain). Findings included: - R1's Electronic Medical Record (EMR) from the "Diagnosis" tab documented diagnoses of nerve pain and herpes zoster (shingles- infection characterized by painful skin eruptions following the route of a nerve). The "Admission Minimum Data Set (MDS)" dated 05/12/2026 documented a Brief Interview of Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented R1 had received opioid medication during the observation period. The MDS documented R1 received pain medication and did not receive non-medication interventions during the observation period. The MDS documented R1 had reported frequent pain, occasionally had difficulty sleeping, and limited her day-to-day activities during the observation period related to pain. The MDS lacked a numerical rating for pain intensity for R1. R1's "Pain Care Area Assessment (CAA)" dated 06/05/2026 documented she triggered for frequent pain.	F0755					

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F0755 SS = D		Continued from page 13 R1's "Care Plan" documented the following interventions: 04/29/2026- Code status: Full code. R1's "Care Plan" lacked any interventions for pain management. R1's EMR under the "Orders" tab revealed the following physician orders: Oxycodone (opioid) hci oral tablet five milligrams (mg) give one tablet by mouth every six hours as needed for pain dated 04/29/26. Tramadol (opioid) hcl oral tablet 50 mg give one tablet by mouth every six hours as needed for pain. Do not exceed 400 mg daily, dated 04/29/2026. Tylenol (pain reliever) oral tablet 325mg (Acetaminophen) give two tablets by mouth every six hours as needed for pain dated 05/02/2026. Review of R1's Medication Administration Record (MAR)" and the "Controlled Drug Receipt/Record/Disposition Form" provided by the facility reviewed from 04/29/2026 to 06/15/2026 (47 days) revealed 25 times oxycodone was documented as administered to R1 on the controlled drug receipt/record/ disposition form but was not documented as administered on R1's MAR. The discrepancies were noted for the following dates: 04/29/2026, 05/01/2026, 05/08/2026, 05/09/2026, 05/10/2026, 05/12/2026, 05/18/2026, 05/20/2026, 05/21/2026, 05/22/2026, 05/23/2026, 05/24/2026 (two times), 05/26/2026, 05/30/2026, 05/31/2026 (two times) 06/01/2026 (two times), 06/04/2026, 06/05/2026, 06/09/2026, 06/13/2026 (two times), and 06/14/2026. On 06/16/2026 at 09:30 AM, R1 laid on her bed in the lowest position. R1 was covered with a blanket to her chest area as she watched TV. R1 stated she had not received her opioid pain medication a few weeks back. R1 stated the facility was unable to administer her pain medication that relieved the shingle pain in her right ear. R1 stated she had been in pain for two days, waiting for her pain medication. On 06/16/2026 at 02:10 PM, Administrative Nurse D stated there probably had been times the nurse had administered R1's oxycodone to treat her pain and forgotten to document the medication on the MAR. Administrative Nurse D stated she had not realized that it had happened as frequently. Administrative Nurse D stated her expectation was the medication		F0755			

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F0755 SS = D	Continued from page 14 was documented on the resident's MAR as it was administered. The facility's "Role of the Provider Pharmacy Services" policy last reviewed 10/2020 documented the facility would have a written agreement with a provider pharmacy to provide regular and reliable pharmacy services to residents, including medications, services, and related equipment and supplies.			F0755			