Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041082	A. BUILDING: _____ B. WING _____	R 06/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA CONCORD OF GREENSBORO	3301 GAR PLACE GREENSBORO, NC 27406

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{D 000}	Initial Comments The Adult Care Licensure Section and the Guilford County Department of Social Services conducted a follow up survey and complaint investigation on June 20-22, 2018 and June 25, 2018.	{D 000}		
{D 131}	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Non compliance continues. Based on record reviews and interviews the facility failed to assure 1 of 6 sampled staff (Staff A) was tested upon hire for tuberculosis (TB) disease. The findings are: Review of Staff A's, medication aide (MA) personnel record revealed: -There was documentation of hire in August 2017, but no documentation of a specific date of hire. -There was documentation of a negative TB skin test read on 09/18/15. -There was documentation of a negative TB skin test read on 11/07/16.	{D 131}	In accordance to 10A NCAC 13F. 0406 section Employee files will be reviewed and updated prior to employment and as needed by facility Administrator. Employees will be required to receive 2-step TB skin test if there is not one available in records and/or within compliance with regulations.	anticipated completion 8-31-18

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: TBaldwin 6899 | TITLE: Administrator | (X6) DATE: 7/30/18

Received and accepted. AJS 08/06/18

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{D 131}	Continued From page 1 -There was no additional documentation of any other TB skin test administered prior to employment at the facility. -There was no documentation of a second TB skin test administered after employment at the facility. Interview with Staff A on 06/22/18 at 12:05 pm revealed: -She worked part-time at the facility "for a while" and then became full time "last August". -"The last time I got a TB skin test was a couple of years ago". -No one at the facility had told her she needed another TB skin test. Interview on 06/22/18 at 12:30 pm with the Administrator revealed: -She was responsible for ensuring all the the required documents were in each staff's employee record. -Staff A was hired as a part time employee. -Staff A became a full time employee of the facility in August 2017, she could not recall the exact date. -She thought the negative 2 TB skin tests provided by Staff A was "okay, because they were both negative". Interview on 06/22/18 at 2:00 pm with the owner of the facility revealed: -Staff A started working part-time at the facility on 11/05/16. -Staff A became a full-time employee on 08/01/17. -The Administrator was responsible to ensure all the required documents for Staff A were obtained.	{D 131}		

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{D 358}	Continued From page 2	{D 358}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 4 residents (#7) observed during the medication pass including an error with insulin administration. The findings are: Review of Resident #7's current FL-2 dated 04/12/18 revealed: -Diagnoses included unspecified asthma, type 2 diabetes mellitus with other diabetic neurological complications, aphasia, hypertension, gastro-esophageal reflux disease, and constipation. -There was an order for Novolog U-100 insulin (a fast-acting insulin used to lower elevated blood sugar levels) inject 4 units subcutaneous three times a day. -There was an order for Novolog 5 units subcutaneous three times a day as needed for blood sugar over 450, recheck blood sugar in one hour if not lower and symptomatic call medical doctor.	{D 358}	In accordance to section 10A NCAC 13F.1400 Medication Administration for ACH/competency validation and controlled medications was conducted Tuesday 6-26-18 at 9am by (Medipack Pharmacist) Nicole B. Med pass will be monitored bi-weekly on 8-2-18 and 8-16-18 by Ellen W, RN (Medipack Nurse Consultant) and daily by facility RCC for one month and as needed. Skills Fair will be conducted at the facility for Med Aids on 8-30-18 by (Medipack Pharmacy)	8-31-18

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{D 358}	Continued From page 3 Observation of the medication aide (MA) obtaining a fingerstick on 06/20/18 at 12:27 pm revealed: -The MA gathered a lancet with Resident #7's labeled pen, Resident #7's glucometer, alcohol pad and alcohol cleaning cloth. -She entered Resident #7's room #104 and checked the resident's blood sugar. -The blood sugar was 79. -The MA then administered 5 units of Novolog insulin to Resident #7 in the right upper abdomen. -The MA returned to the medication cart and logged in and signed that the Novolog insulin 4 units was administered. Review of Resident #7's June 2018 electronic medication administration record (eMAR) revealed: -There was an entry for Novolog flex pen inject 4 units subcutaneous three times daily with meals, scheduled for administration at 7:30 am, 11:30 am, and 4:30 pm, documented as administered (not observed as administered during 11:30 am medication pass). -There was an entry for Novolog 100 units/ml flex pen inject 5 units under the skin 3 times daily as needed for blood sugar more than 450, recheck in one hours and notify provider if still more than 450, not documented as administered during the entire month of June 2018 (observed as administered during the medication pass on 06/20/18 at 11:30 am). -There was no documentation of a blood sugar equal to or greater than 450. Observation of Resident #7's medications on hand and available for administration on 06/20/18 at 12:51 pm revealed: -There was one Novolog flex pen labeled as	{D 358}		

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{D 358}	Continued From page 4 opened 05/18/18 and inject 5 units under the skin 3 times daily as needed for blood sugar more than 450. -There were two Novolog flex pens labeled as not opened and inject 4 units subcutaneous three times daily with meals available for Resident #7 in the overstock/medication closet. Observation of Resident #7 after insulin administration on 06/20/18 at 1:03 pm: -Resident #7 was in her room sitting on the bed. -Resident #7 had not eaten lunch. -Resident #7 ate three peanut butter sandwich crackers. -Resident #7 was alert and fed herself. Observation of Resident #7 on 06/20/18 at 1:30 pm revealed: -Resident #7 was in the facility dining room. -She was alert and request a glass of juice. -She was eating a chicken salad on croissant and drinking a glass of milk. Interview with the MA who administered insulin to Resident #7 on 06/20/18 at 12:30 pm revealed: -She did not look at the insulin order for Resident #7 prior to going into the resident's room. -She knew the dose to administer to Resident #7 by looking at the label on the insulin flex pen. -She administered 5 units of Novolog insulin, which was what the label read. -She always looked at the label of medications to use for administration instead of the computer because there were problems with new orders being placed in the computer by pharmacy. -She only looked at the label of the medications that were administered because there was an issue with paperwork. -If she noted an error or problem she told the RCC.	{D 358}		

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{D 358}	Continued From page 5 -She knew Resident #7 had an order for Novolog 4 units but that flex pen was not on the medication cart. -The Novolog flex pen labeled with the 4 units three times a day may be in the medication closet which was near the desk, but she was unsure. -She had not attempted to locate the Novolog flex pen labeled with the 4 units three times a day. -She had not told the Resident Care Coordinator (RCC) that she did not have the Novolog flex pen labeled with the order 4 units on the medication cart. Interview with Resident #7's Nurse Practitioner (NP) on 06/21/18 at 2:00 pm revealed: -She had seen Resident #7 twice on May 2018 and June 2018. -An order for Novolog 4 units four times a day hold for a blood sugar less than 100 or not eating, Novolog 5 units as needed for blood sugar over 450 was written for Resident #7. -The facility did not notify her on 06/21/18 about the incorrect amount of insulin administered on 06/20/18. -She was told on 06/21/18 by the RCC about the incorrect amount of insulin administered on 06/20/18. -She told the RCC that she wanted to be notified for low blood sugar readings and high blood sugar readings. -She told the RCC that MAs needed additional training on diabetes care. Interview with RCC on 06/20/18 at 1:11 pm revealed: -She had worked for the facility for two months. -She worked as a MA during staff shortages. -The MAs were to look at the order on the computer prior to administering a medication. -The order on the computer for a specific resident	{D 358}		

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{D 358}	Continued From page 6	{D 358}		

was supposed to be compared with the medication label and medication removed from the medication cart.
-Only after all these items were checked should the MAs administer a medication.
-She did not know one of the MAs was using the medication label to administer units of insulin.
-The MAs were told several times the steps for administering medication.
-Some of the MAs returned to their old way of administering medications even after training and repeated counseling.
-The last training was completed by pharmacy nurse on May 2018.
-The pharmacy nurse also observed medication passes.
-She was unsure if the facility had a policy for medication errors.
-She handled medication errors based on what she had done in the past at other facilities, by completing a medication error form, notifying the pharmacy and the physician, and did whatever instructed to do by the physician.
-She did notify Resident #7's NP on 06/20/18 about the administration of the incorrect dose of insulin.
-The NP recommended diabetic training and insulin administration training for all the MAs to be conducted by the NP and/or a home health nurse
-Each MA was responsible for accurately administering medications when they were on duty.

Interview with the Administrator on 06/25/18 at 9:34 am
-She was told about the insulin error by the RCC on 06/20/18.
-She did not know a MA used the medication label to administer insulin or any other medications.

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{D 358}	Continued From page 7 -The MAs received training from the pharmacy nurse May 2018 on diabetic care and medication administration. -Each MA was responsible for administering medications correctly. -She and the RCC were responsible for providing the training to the MAs. Attempted interviews with Resident #7's family member on 06/21/18 at 11:36 am and 3:54 pm were unsuccessful.	{D 358}		
{D 392}	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure records of the receipt and administration of controlled substances were maintained, accurate and reconciled for 2 of 4 residents sampled (#5 and #8) who were prescribed controlled substances including Percocet (#5), and lorazepam (#8). The findings are: 1. Review of Resident #5's current FL2 dated 04/26/18 revealed: -Diagnoses included diabetes mellitus type 2, chronic obstructive pulmonary disease, hypertension, congestive heart failure, asthma,	{D 392}	In accordance to section 10A NCAC 13F. 1008 Controlled sheets and controlled medication will be monitored weekly and as needed by facility RCC and Administrator. Facility implemented an inventory feature to EMAR on 7-10-18 ; along with paper control sheets for proper medication variance. Inventory feature requires witness signature to ensure proper count.	7-10-18

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{D 392}	Continued From page 8	{D 392}		

osteoarthritis, pancreatic insufficiency, a pacemaker, and schizoaffective disorder.
-There was a physician's order for Percocet 5-325mg (for moderate to severe pain) three times daily as needed for pain.

Review of Resident #5's record revealed:
-There were prescriptions written for Percocet 5-325 mg dated 03/22/18, 04/26/18, and 05/31/18.
-There was a hospital FL2 and discharge summary report dated 05/26/18 with an order for Percocet 5-325mg three times daily as needed for pain.

Review of Resident #5's April 2018 Medication Administration Records (MARs) revealed:
-There was an entry for Percocet 5-325mg administer three times daily as needed for pain.
-Percocet 5-325mg was documented as administered twice on 04/21/18, 04/23/18, and 04/29/18.
-Percocet 5-325mg was documented as administered once on 04/22/18, 04/28/18, and 04/30/18.
-Percocet was documented as administered 9 times from 04/21/18 to 04/30/18 on the April MAR.

Review of Resident #5's Controlled Substance Count Sheet (CSCS) for Percocet 5-325mg revealed:
-Percocet was dispensed on 03/22/18 for a quantity of 90 tablets and documented as administered from 04/21/18 to 04/23/18, and from 04/28/18 to 04/30/18.
-Compared to Resident #5's April 2018 MAR there were 6 doses of Percocet 5-325 mg signed out as administered on the CSCS, but not documented as administered on the April 2018

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{D 392}	Continued From page 9	{D 392}		

MAR.
-There were also 2 doses of Percocet not accounted for on the CSCS on 04/14/18 and 04/18/18.

Examples of Percocet doses documented on the CSCS but not the MAR included:
-Percocet 5-325mg was signed out as administered once on 04/21/18, 04/23/18, 04/29/18, and 04/30/18.
-Percocet 5-325mg was signed out as administered twice on 04/28/18 at 2:00 pm and 8:00 pm.

Review of Resident #5's May 2018 MARs revealed:
-There was an entry for Percocet 5-325mg administer three times daily as needed for pain.
-The MARs documentation ended on 05/23/18.
-Percocet 5-325mg was documented as administered once on 05/01/18, 05/02/18, 05/03/18, 05/06/18, 05/08/18, 05/10/18, 05/11/18, 05/13/18, 05/17/18, 05/18/18, 05/20/18, and 05/22/18.
-Percocet 5-325mg was documented as administered twice on 05/05/18, 05/07/18, 05/09/18, 05/12/18, 05/14/18, 05/15/18, 05/16/18, and 05/19/18.
-Percocet was documented as administered 28 times on the May MAR from 05/01/18 to 05/22/18.

Review of Resident #5's hospital discharge summary dated 05/26/18 revealed that the resident was admitted on 05/22/18 for acute on chronic heart failure and discharged on 05/26/18.

Review of Resident #5's May electronic medication administration record (eMAR) for dates 05/23/18 through 05/31/18 revealed:

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{D 392}	Continued From page 10 -There was an entry for Percocet 5-325mg administer three times daily as needed for pain. -No medications were documented as administered for 05/23/18 through 05/25/18. -Percocet 5-325mg was documented as administered once on 05/26/18, 05/27/18, 05/28/18, 05/29/18, and 05/31/18. -Percocet 5-325mg was documented as administered twice on 05/31/18. -Percocet was documented as administered 7 times on the May eMAR from 05/16/18 to 05/31/18. Review of Resident #5's CSCS for Percocet 5-325mg revealed: -Compared to Resident #5's May 2018 MAR and May 2018 eMAR, there were 34 doses of Percocet 5-325 mg signed out as administered on the CSCS, but not documented as administered on the May 2018 MAR and eMAR. Examples of Percocet doses documented on the CSCS but not the MAR included: -Percocet 5-325mg was signed out as administered twice on 05/01/18, 05/02/18, 05/08/18, 05/11/18, 05/13/18, 05/14/18, 05/20/18, 05/27/18, and 05/30/18. -Percocet 5-325mg was signed out as administered once on 05/06/18, 05/10/18, 05/12/18, 05/16/18, 05/17/18, 05/18/18, 05/19/18, 05/22/18, 05/28/18, and 05/31/18. -Percocet 5-325mg was signed out as administered three times on 05/21/18. Review of Resident #5's June 2018 eMARs revealed: -There was an entry for Percocet 5-325mg administer three times daily as needed for pain. -Percocet 5-325mg was documented as administered three times on 06/01/18, 06/02/18,	{D 392}		

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06/03/18, 06/04/18, 06/08/18, 06/13/18, and 06/15/18.
-Percocet 5-325mg was documented as administered once on 06/05/18, 06/09/18, 06/11/18, 06/16/18, 06/17/18, and 06/20/18.
-Percocet 5-325mg was documented as administered twice on 06/06/18, 06/07/18, 06/12/18, 06/14/18, 06/18/18, and 06/19/18.
-Percocet was documented as administered 42 times on the June eMAR from 06/01/18 to 06/20/18.

Review of Resident #5's CSCS for Percocet 5-325mg revealed:
-There was 1 dose of Percocet 5-325 mg signed out as administered on 06/08/18 at 8:59 am on the June 2018 MAR and not accounted for on the CSCS.
-Compared to Resident #5's and June 2018 eMAR, there were 20 doses of Percocet 5-325 mg signed out as administered on the CSCS, but not documented as administered on the June 2018 eMAR.

Examples of Percocet doses documented on the CSCS but not the MAR included:
-Percocet 5-325mg was signed out as administered once on 06/02/18, 06/07/18, 06/09/18, 06/11/18, 06/14/18, 06/15/18, and 06/20/18.
-Percocet 5-325mg was signed out as administered twice on 06/06/18, 06/08/18, 06/12/18, 06/16/18, and 06/17/18.
-Percocet 5-325mg was signed out as administered on 06/10/18 at 9:00 am, 2:00 am, 8:00 pm and 8:00 pm (in that order).

Observation on 06/25/18 at 10:30 am of Resident #5's medications on hand at the facility revealed:
-Percocet 5-325mg was available for

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(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) COMPLETE DATE
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administration.
-According to the pharmacy printed label, the medication was filled and dispensed on 06/01/18 for 90 tablets.
-There were 52 tablets remaining.

Interview on 06/21/18 at 1:30 pm with Resident #5's primary care provider revealed:
-She prescribed Percocet for Resident #5's chronic pain.
-The facility often asked for refills early, but she did not issue refills until time.
-She administered random drug screens to the residents taking controlled medications.
-Resident #5 had been screened in April and her drug levels were below therapeutic level, indicating she was not receiving the medication as expected.
-She had ordered the Percocet three times a day as needed, rather than scheduled, so that the resident would have to ask for the medication specifically.
-She did this to try and cut down on possible abuse or diversion from the facility so they would have to document on the MAR each time the resident asked for Percocet.
-She knew there had been "issues in the past" with documenting controlled substances at the facility but did not know what, if anything, had been done to address it.

Interview on 06/21/18 at 4:03 pm with Resident #5 revealed:
-She was ordered Percocet three times a day because she was continually in pain.
-She went to the hospital on 05/23/18 and returned to the facility on 05/26/18.
-She had to ask for her Percocet because it was on an as needed basis.

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	HAL041082	A. BUILDING: _____ B. WING _____	R 06/25/2018

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Interview on 06/21/18 at 4:30 pm with the Resident Care Coordinator (RCC) revealed:
-She had started working at the facility on 03/17/18.
-She had been told by the owner that there were problems with documenting controlled substances prior to her arrival.
-The staff that had been responsible for the problems with controlled substances no longer worked at the facility.
-She had documented on the resident's CSCS that she administered Percocet to the resident.
-She always documented on the MAR and the CSCS whenever she administered Resident #5's Percocet.
-Staff were expected to document on both the CSCS and MAR when administering controlled substances.
-She did not think Resident #5 had missed any doses of medication, but staff were just not documenting correctly.
-Resident #5 asked for her Percocet three times a day.

Interview on 06/21/18 at 1:45 pm with the contracted pharmacy revealed:
-Resident #5's Percocet 5-325mg was filled on 05/03/18, and 90 tablets were dispensed.
-The medication should have lasted until 06/03/18.
-Percocet was filled on 06/01/18, and 90 tablets were dispensed.
-The medication should last until 07/01/18.
-They did not fill refill requests for controlled substances early.

Interview on 06/25/18 at 11:00 am with the Administrator revealed:
-She realized there were issues with documentation of controlled substances and was

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{D 392}	Continued From page 14 working to correct them. -The expectation was for staff to sign both the CSCS and the MAR or now eMAR when administering controlled substances. -Resident #5 always asked for her Percocet 3 times a day. -She thought staff were forgetting to document in both places when administering the Percocet, but that this was getting better since switching over from paper to electronic MARs. -She had begun to audit the CSCS against the MARs to identify problems. 2. Review of Resident #8's current FI-2 dated 04/12/18 revealed: -Diagnosis included anxiety with depression. -There was a medication order for Ativan 0.5 mg (used to treat anxiety) take one tablet at 12 noon as needed (prn). Review of Resident #8's April 2018 MAR revealed: -There was an entry for lorazepam/Ativan 0.5 mg tablet take one tablet at 12 noon as needed prn. -There was no documentation of administration on 04/25/18. -A dose of lorazepam was documented as administered on the other dates of the month of April 2018 from 4/21/18 to 4/30/18. -There were a total dose of 9 tablets documented as administered from 4/21/18 to 4/30/18. Review of Resident #8's April 2018 controlled substance count sheet (CSCS) for lorazepam 0.5 mg revealed there was one dose of lorazepam signed out as administered on 04/25/18 at 8:00 am. Review of Resident #8's May 2018 MAR revealed:	{D 392}		

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{D 392}	Continued From page 15 -There was an entry for lorazepam/Ativan 0.5 mg tablet take one tablet at 12 noon as needed prn. -There was no documentation of administration on 05/01/18, 05/02/18, 05/07/18 through 05/13/18, 05/16/18, 05/22/18 and 05/23/18. -There were a total of 20 tablets documented as administered on the May MAR from 05/01/18 to 05/31/18. Review of Resident #8's May 2018 CSCS for lorazepam 0.5 mg tablets revealed: -There was one dose of lorazepam documented as administered on 05/01/18 at 12:00 pm. -There was one dose of lorazepam documented as administered on 05/02/18 at 12:00 pm. -There was one dose of lorazepam documented as administered on 05/07/18 (no time was documented). -There was one dose of lorazepam documented as administered on 05/08/18, 05/11/18, and 05/12/18. -There were two doses of lorazepam documented as administered on 05/13/18 at 12:00 pm and 8:00 pm. -There was one dose of lorazepam documented as administered on 05/16/18, 05/22/18 and 05/23/18 at 12:00 pm. -There were a total of 11 tablets documented as administered on the May MAR from 05/01/18 to 05/23/18. Review of Resident #8's May 2018 CSCS revealed seven doses of lorazepam signed out as administered from 05/01/18 to 05/23/18. Interview with a medication aide (MA) on 06/21/18 at 10:35 am revealed: -There were two medication carts and the carts were assigned to specific halls within the facility. -There was one controlled substance log book	{D 392}		

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used to sign for controlled medications administered to residents.
-She administered controlled medications based on the order in the computer.
-She first looked at the order for controlled medications, placed the correct amount of medication in the medication cups, administered the medication and then clicked the medication on the computer screen.
-If the controlled medication log book was on the opposite cart of the one she was using, she signed off the administered controlled medications later in the shift.

Interview with Resident Care Coordinator (RCC) on 06/22/18 at 3:40 pm revealed:
-She began working at the facility March 2018.
-She was told about previous problems with documentation on the MARs and on the CSCS.
-The majority of the MAs who did not document, administer medications, and controlled medications were no longer working at the facility.
-The MARs were audited each week.
-She audited the MARs for documentation, discontinued medications and accurate medication order.
-She was responsible for auditing the MARS and eMARs when the facility switched as of 05/24/18.
-The MAs were told to sign both the MAR or eMAR and the controlled substance log book before the facility switched to electronic MARs on 05/24/18.
-She also audited the CSCS daily when she arrived at work.
-She audited the CSCS for times, signatures and the actual number listed on the log versus amount on the medication cart.
-She last audited the CSCS and eMARs on 06/18/18.
-She did not compare the April 2018 and May

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{D 392}	Continued From page 17 2018 MARs to the CSCS. -She did not know about the missed documentation for lorazepam on Resident #8's April 2018 and May 2018 MARs. Interview with Administrator on 06/25/18 at 10:45 am revealed: -She knew Resident #8 was ordered lorazepam as needed daily. -She did not know that the documentation of administration of Resident #8's lorazepam was not on the April 2018 MAR for 04/16/18 and 04/25/18. -She did not know that the documentation of administration of Resident #8's lorazepam was not on the May 2018 MAR for 05/01/18, 05/02/18, 05/07/18 through 05/13/18, 05/16/18, 05/22/18 and 05/23/18. -She knew about the previous issues the facility had with documentation of controlled substances and she and the RCC were working to fix the issues by providing training for the MAs. -When the MAs administered medications, they were responsible for documenting on the MAR and the CSCS. -She noticed an improvement when the facility switched over to electronic MARs.	{D 392}		