STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(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
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 01/02/2020.	{D 000}		
{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, interviews and record reviews the facility failed to administer medications as ordered for 2 of 5 sampled residents (#4 and #2) with medications used to treat dementia, prevent blood clots, fluid retention, and low potassium (#4) and one medications used to treat depression, and a medication to used to treat side effects from certain medications (#2). The findings are: Review of Resident #4's current FL-2 dated 06/10/19 revealed diagnoses included dementia, post-traumatic stress disorder, hypertension, gout, hypothyroidism, atrial fibrillation, and hyperlipidemia. a. Review of physician orders for Resident #4 dated 10/31/19 revealed a medication order for donepezil (to treat dementia) 10mg tablet daily.	{D 358}		

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{D 358}	Continued From page 1 Review of the November 2019 electronic medication administration records (eMARs) for Resident #4 revealed: -There was an entry for donepezil 10mg tablet take one tablet every day scheduled at 8:00am. -Donepezil 10mg was documented as not administered for 7 out of 30 opportunities from 11/01/19 to 11/30/19. -There were parentheses around the staff initials for documenting administration for the donepezil from 11/01/19 through 11/05/19, and 11/28/19 through 11/29/19. -The reason/comments for these dates indicated the medication was not administered because the staff was waiting on the pharmacy to refill the medication. Observation of Resident #4's available medications on hand on 01/02/20 at 3:00pm revealed: -There was a bubble pack of donepezil 10mg tablets with 12 tablets remaining available for administration. -The dispense date on the bubble pack was 12/29/19. -The quantity dispensed was 15 tablets. Review of Resident #4's pharmacy requests for refills of medications on 01/02/19 revealed the donepezil 10mg tablets had not been requested for refill prior to 11/01/19 and 11/29/19. Telephone interview with a representative from the contracted pharmacy on 01/02/19 at 2:00pm revealed: -Resident #4 had a current physician order for donepezil 10mg tablet daily with instructions to be refilled for twelve months beginning 10/31/19. -Resident #4's donepezil 10mg tablet daily was not dispensed to the facility in the multidose	{D 358}		

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{D 358}	Continued From page 2	{D 358}		

packaging (MDP) system which was automatically refilled on a weekly basis.
-A fifteen-day supply was delivered to the facility on 10/01/19, 11/07/19, and 11/29/19.

Interview with a first shift medication aide (MA) on 01/02/19 at 3:05pm revealed:
-She faxed requests for Resident #4's donepezil refill to the pharmacy approximately 5-7 days before he no longer had any donepezil left to administer.
-She could not remember what day the fax was sent.
-She always called the pharmacy and confirmed the request was received.
-She informed the Resident Care Coordinator (RCC) when the medication did not arrive the next day.
-She did not continue to contact the pharmacy because she was told the RCC would contact them.

Interview with the weekend shift MA on 01/02/19 at 3:20pm revealed:
-When Resident #4's donepezil was not available on 11/02/19 she contacted the MA assigned to the shift before her shift to ask if the donepezil had been requested from the pharmacy.
-She was told a request for refill of the donepezil was faxed to the pharmacy.
-She did not contact the pharmacy to ask for the donepezil because the pharmacy did not deliver to the facility on Sundays.
-She did not tell the RCC about the missing donepezil.

Interview with a second shift MA on 01/02/19 at 3:30pm revealed:
-She called the pharmacy and requested Resident #4's donepezil.

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{D 358}	Continued From page 3	{D 358}		

-She could not remember what day she contacted the pharmacy to request the donepezil.
-The pharmacy told her the medication would be sent the next day with the scheduled delivery.
-She did not fax a refill request to the pharmacy.
-She did not notify the RCC the donepezil was not available.

Refer to the interview with the RCC on 01/02/19 at 4:00pm.

Refer to the interview with the Administrator 01/02/19 at 4:07pm.

Attempted interview with Resident #4's primary care provider (PCP) on 01/02/19 at 2:52pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.

b. Review of physician orders for Resident #4 dated 10/31/19 revealed a medication order for apixaban (to prevent blood clots) 5mg tablet twice daily.

Review of the November 2019 electronic medication administration records (eMARs) for Resident #4 revealed:
-There was an entry for apixaban 5mg tablet take one tablet twice daily scheduled at 8:00am and 8:00pm.
-Apixaban 5mg was documented as not administered for 8 out of 30 opportunities from 11/01/19 to 11/30/19.
-There were parentheses around the staff initials for documenting administration for the apixaban from 11/17/19 through 11/20/19.
-The reason/comments for these dates indicated

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{D 358}	Continued From page 4 the medication was not administered because the staff was waiting on the pharmacy to refill the medication. Observation of Resident #4's available medications on hand on 01/02/20 at 3:00pm revealed: -There was a bubble pack of apixaban 5mg tablets with 24 tablets remaining available for administration. -The dispense date on the bubble pack was 12/29/19. -The quantity dispensed was 30 tablets. Review of Resident #4's pharmacy requests for refills of medications on 01/02/19 revealed the apixaban 5mg tablets had not been requested for refill prior to 11/17/19. Telephone interview with a representative from the contracted pharmacy on 01/02/19 at 2:00pm revealed: -Resident #4 had a current physician order for apixaban 5mg tablet twice daily with instructions to be refilled for twelve months beginning 10/31/19. -Resident #4's apixaban 5mg tablet twice daily was not dispensed to the facility in the multidose packaging system (MDP) that was automatically refilled weekly. -A fifteen-day supply was delivered to the facility on 10/01/19, 11/07/19, and 11/20/19. Interview with a first shift medication aide (MA) on 01/02/19 at 3:05pm revealed: -She faxed requests for Resident #4's apixaban refill to the pharmacy. -She could not remember what day the fax was sent. -She always called the pharmacy and confirmed	{D 358}		

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{D 358}	Continued From page 5	{D 358}		

the request was received.
-She informed the Resident Care Coordinator (RCC) when the medication did not arrive the next day.
-She did not continue to contact the pharmacy because she was told the RCC would contact them.

Interview with the weekend shift MA on 01/02/19 at 3:20pm revealed:
-When Resident #4's apixaban was not available she contacted the MA assigned to the shift before her shift to ask if the apixaban had been requested from the pharmacy.
-She was told a request for refill of the apixaban was faxed to the pharmacy.
-She did not contact the pharmacy to ask for the apixaban because the pharmacy did not deliver to the facility on Sundays.
-She did not tell the RCC about the missing apixaban on 11/17/19.

Interview with a second shift MA on 01/02/19 at 3:30pm revealed:
-She called the pharmacy and requested Resident #4's apixaban on 11/18/19.
-The pharmacy told her the medication would be sent the next day with the scheduled delivery.
-She did not fax a refill request to the pharmacy.
-She did not notify the RCC the apixaban was not available.

Refer to the interview with the RCC on 01/02/19 at 4:00pm.

Refer to the interview with the Administrator 01/02/19 at 4:07pm.

Attempted interview with Resident #4's primary care provider (PCP) on 01/02/19 at 2:52pm was

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{D 358}	Continued From page 6 unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. c. Review of physician orders for Resident #4 dated 10/31/19 revealed a medication order for furosemide (to treat fluid retention) 20mg tablet daily. Review of the November 2019 electronic medication administration records (eMARs) for Resident #4 revealed: -There was an entry for furosemide 20mg tablet take one tablet every day scheduled at 8:00am. -Furosemide 20mg was documented as not administered for 9 out of 30 opportunities from 11/01/19 to 11/30/19. -There were parentheses around the staff initials for documenting administration for the furosemide from 11/01/19 through 11/04/19, and 11/23/19 through 11/27/19. -The reason/comments for these dates indicated the medication was not administered because the staff was waiting on the pharmacy to refill the medication. Observation of Resident #4's available medications on hand on 01/02/20 at 3:00pm revealed: -There was a bubble pack of furosemide 20mg tablets with 12 tablets remaining available for administration. -The dispense date on the bubble pack was 12/29/19. -The quantity dispensed was 15 tablets. Review of Resident #4's pharmacy requests for refills of medications on 01/02/19 revealed the	{D 358}		

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{D 358}	Continued From page 7 furosemide 20mg tablets had not been requested for refill prior to 11/01/19, 11/23/19, 11/28/19. Telephone interview with a representative from the contracted pharmacy on 01/02/19 at 2:00pm revealed: -Resident #4 had a current physician order for furosemide 20mg tablet daily with instructions to be refilled for twelve months beginning 10/31/19. -Resident #4's furosemide 20mg tablet daily was not dispensed to the facility in the multidose packaging system (MDP) that was automatically refilled weekly. -A fifteen-day supply was delivered to the facility on 10/01/19, 11/07/19, and 11/29/19. Interview with a first shift medication aide (MA) on 01/02/19 at 3:05pm revealed: -She faxed requests for Resident #4's furosemide refill to the pharmacy. -She could not remember what day the fax was sent. -She always called the pharmacy and confirmed the request was received. -She informed the Resident Care Coordinator (RCC) when the medication did not arrive the next day. -She did not continue to contact the pharmacy because she was told the RCC would contact them. Interview with the weekend shift MA on 01/02/19 at 3:20pm revealed: -When Resident #4's furosemide was not available she contacted the MA assigned to the shift before her shift to ask if the furosemide had been requested from the pharmacy. -She was told a request for refill of the furosemide was faxed to the pharmacy. -She did not contact the pharmacy to ask for the	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{D 358}	Continued From page 8 furosemide because the pharmacy did not deliver to the facility on Sundays. -She did not tell the RCC about the missing furosemide. Interview with a second shift MA on 01/02/19 at 3:30pm revealed: -She called the pharmacy and requested Resident #4's furosemide. -The pharmacy told her the medication would be sent the next day with the scheduled delivery. -She did not fax a refill request to the pharmacy. -She did not notify the RCC the furosemide was not available. Refer to the interview with the RCC on 01/02/19 at 4:00pm. Refer to the interview with the Administrator 01/02/19 at 4:07pm. Attempted interview with Resident #4's primary care provider (PCP) on 01/02/19 at 2:52pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. d. Review of physician orders for Resident #4 dated 10/31/19 revealed a medication order for potassium chloride (to treat low potassium) 20mEq tablet daily. Review of the November 2019 electronic medication administration records (eMARs) for Resident #4 revealed: -There was an entry for potassium chloride 20mEq tablet take one tablet every day scheduled at 8:00am.	{D 358}		

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{D 358}	Continued From page 9 -Potassium 20 mEq was documented as not administered for 11 out of 30 opportunities from 11/01/19 to 11/30/19. -There were parentheses around the staff initials for documenting administration for the potassium chloride from 11/01/19 through 11/05/19, 11/08/19 through 11/09/19, and 11/24/19 through 11/29/19. -The reason/comments for these dates indicated the medication was not administered because the staff was waiting on the pharmacy to refill the medication. Observation of Resident #4's available medications on hand on 01/02/20 at 3:00pm revealed: -There was a bubble pack of potassium chloride 20 mEq tablets with 13 tablets remaining available for administration. -The dispense date on the bubble pack was 12/29/19. -The quantity dispensed was 15 tablets. Review of Resident #4's pharmacy requests for refills of medications on 01/02/19 revealed the potassium chloride 20mEq tablets had not been requested for refill prior to 11/01/19, 11/29/19. Telephone interview with a representative from the contracted pharmacy on 01/02/19 at 2:00pm revealed: -Resident #4 had a current physician order for potassium chloride 20mEq tablet daily with instructions to be refilled for twelve months beginning 10/31/19. -Resident #4's potassium chloride 20mEq tablet daily was not dispensed to the facility in the multidose packaging system (MDP) that was automatically refilled weekly. -A fifteen-day supply was delivered to the facility on 10/01/19, 10/17/19, 11/20/19, and 12/03/19.	{D 358}		

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{D 358}	Continued From page 10 Interview with a first shift medication aide (MA) on 01/02/19 at 3:05pm revealed: -She faxed requests for Resident #4's potassium chloride refill to the pharmacy. -She could not remember what day the fax was sent. -She always called the pharmacy and confirmed the request was received. -She informed the Resident Care Coordinator (RCC) when the medication did not arrive the next day. -She did not continue to contact the pharmacy because she was told the RCC would contact them. Interview with the weekend shift MA on 01/02/19 at 3:20pm revealed: -When Resident #4's potassium chloride was not available she contacted the MA assigned to the shift before her shift to ask if the potassium chloride had been requested from the pharmacy. -She was told a request for refill of the potassium chloride was faxed to the pharmacy. -She did not contact the pharmacy to ask for the potassium chloride because the pharmacy did not deliver to the facility on Sundays. -She did not tell the RCC about the missing potassium chloride. Interview with a second shift MA on 01/02/19 at 3:30pm revealed: -She called the pharmacy and requested Resident #4's potassium chloride. -The pharmacy told her the medication would be sent the next day with the scheduled delivery. -She did not fax a refill request to the pharmacy. -She did not notify the RCC the potassium chloride was not available.	{D 358}		

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{D 358}	Continued From page 11 Refer to the interview with the RCC on 01/02/19 at 4:00pm. Refer to the interview with the Administrator 01/02/19 at 4:07pm. Attempted interview with Resident #4's primary care provider (PCP) on 01/02/19 at 2:52pm was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. 2. Review of Resident #2's current FL2 dated 02/27/19 revealed diagnoses included Alzheimer's dementia and urinary tract infection. a. Review of Resident #2's current FL2 dated 02/27/19 revealed there was an order for mirtazapine (used to treat depression) 15mg one tablet at bedtime. Review of Resident #2's signed physician's order dated 09/25/19 revealed there was an order for mirtazapine 15mg one tablet at bedtime. Review of Resident #2's December 2019 eMAR revealed: -There was an entry for mirtazapine 15mg one tablet daily scheduled daily at 8:00pm. -Mirtazapine 15mg was documented as not administered for 11 out of 31 opportunities from 12/01/19 to 12/31/19. -Mirtazapine 15mg was documented as not administered 12/14/19-12/16/19, 12/18-12/22/19, 12/27/19, and 12/30-12/31/19 due to "awaiting pharmacy". Observation of Resident #2's available	{D 358}		

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{D 358}	Continued From page 12	{D 358}		

medications on hand on 01/02/20 at 10:20am revealed:
-There was a bubble pack of mirtazapine 15mg tablets with 30 tablets remaining available for administration.
-The dispense date on the bottle was 12/31/19.
-The quantity dispensed was 30 tablets.

Telephone interview with a representative from the contracted pharmacy on 01/02/20 at 1:45pm revealed:
-The pharmacy had an order dated 09/25/19 for mirtazapine 15mg one tablet at bedtime for Resident #2.
-The pharmacy dispensed 30 tablets of mirtazapine on 10/05/19, 12 tablets on 10/28/19, and 30 tablets on 12/31/19.
-Resident #2 would have ran out of mirtazapine 15mg on 11/16/19 if administered as ordered.
-Resident #2 was a Hospice patient and the pharmacy only dispensed a 15-day supply of medications.
-Residents who were under Hospice care were not on cycle fill, staff would need to reorder medications either via telephone call or fax before it was sent to the pharmacy.
-She did not have any correspondence with the facility requesting mirtazapine 15mg in November 2019.

Review of Resident #2's progress notes revealed there was not documentation correspondence had been made with the pharmacy to refill Resident #2's medications.

Interview with a medication aide (MA) on 01/02/20 at 2:21pm revealed:
-She was not able to administer mirtazapine to Resident #2 when she worked because it was pending from pharmacy.

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-She contacted the pharmacy via fax to get mirtazapine delivered to the facility.
-She did not know why it took so long for the pharmacy to deliver the medication.
-She did not document in the resident's record that she attempted to get the mirtazapine dispensed.
-MAs were responsible for requesting medication refills from the pharmacy when the medications were "running low".
-MAs were not supposed to wait until the medication ran out to prevent missed dosages.
-She could not find any correspondence in November or December 2019 where refills were requested for mirtazapine.

Interview with another MA on 01/02/20 at 3:30pm revealed:
-She normally worked as a 2nd shift MA.
-She documented Resident #2's mirtazapine was not administered on 12/01/19-12/22/19 and 12/31/19.
-Each shift that she worked, she wrote down all medications that were missing and gave the list to the other MA working with her so that the medications could be ordered.
-She began working as a MA in December 2019 and did not communicate with the pharmacy to request refills.
-She did not know why the mirtazapine 15mg was not available for administration on those dates.
-She did not know Resident #2's medications had to be reordered every 15 days.

Interview with the Resident Care Coordinator (RCC) on 01/02/20 at 3:52pm revealed:
-She did not realize Resident #2 missed 11 doses of mirtazapine in December 2019.
-MAs were supposed to request refills from the pharmacy 7 days prior to running out of the

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	HAL060150	A. BUILDING: _____ B. WING _____	R 01/02/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHLAKE HOUSE	9108-REAMES ROAD CHARLOTTE, NC 28216

(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
{D 358}	Continued From page 14	{D 358}		

medication.
-She had notified all MAs that residents under hospice care only received a 15-day supply of medications and they needed to be ordered to prevent residents from running out.
-Every few days she tried to pull a missed medication report, however had not noticed that mirtazapine had not been administered to Resident #2 in December 2019.
-She expected MAs to let her know if they were having problems getting medications from the pharmacy timely.

Interview with the Administrator on 01/02/20 at 3:54pm revealed:
-She expected MAs to order medications 7 days before running out of the medications to ensure that it was in the building before running out.
-She felt the MAs always ordered medications timely, she did not know why the mirtazapine was not delivered timely.
-She expected the RCC to run a compliance report daily with all the exceptions to catch medications not administered.

Attempted telephone call to Resident #2 mental health provider on 01/02/20 at 4:00pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable.

Refer to interview with the RCC on 01/02/19 at 4:00pm.

Refer to interview with the Administrator on 01/02/19 at 4:07pm.

b. Review of a signed physician's order for

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{D 358}	Continued From page 15 Resident #2 dated 10/16/19 revealed there was an order for amantadine (used to treat side effects from certain medications) 100mg one half tablet every morning. Review of Resident #2's November 2019 electronic Medication Administration Record (eMAR) revealed: -There was an entry for amantadine 100mg one half tablet every morning scheduled at 8:00am. -Amantadine 100mg was documented as administered from 11/01/19-11/30/19, except for 11/28/19 due to "awaiting". Review of Resident #2's December 2019 eMAR revealed: -There was an entry for amantadine 100mg one half tablet every morning scheduled at 8:00am. -Amantadine 100mg was documented as not administered for 8 out of 31 opportunities from 12/01/19 to 12/31/19. -Amantadine 100mg was documented as not administered 12/02/19-12/10/19 due to "awaiting". Observation of Resident #2's available medications on hand on 01/02/20 at 10:20am revealed: -There was a bubble pack of amantadine 100mg tablets with 4 half tablets remaining available for administration. -The dispense date on the bubble pack was 12/10/19. -The quantity dispensed was 15 tablets. Telephone interview with a representative from the contracted pharmacy on 01/02/20 at 1:45pm revealed: -The pharmacy had an order dated 10/16/19 for amantadine 100mg one half tablet every morning for Resident #2.	{D 358}		

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{D 358}	Continued From page 16 -The pharmacy dispensed 12 tablets of amantadine 100mg on 10/16/19, 2.5 tablets on 11/07/19, and 15 tablets on 12/10/19. -Resident #2 would have ran out of amantadine on 11/15/19 if administered as ordered. -Resident #2 was a Hospice patient and the pharmacy only dispensed a 15-day supply of medications. -Residents who were under Hospice care was not on cycle fill, staff would need to reorder medications either via telephone call or fax before it was sent to the pharmacy. -She did not have any correspondence in which the facility requested refills of amantadine between 11/07/19-12/09/19. Review of Resident #2's progress notes revealed there was not documentation correspondence had been made with the pharmacy to refill Resident #2's medications. Interview with a medication aide (MA) on 01/02/20 at 3:31pm revealed: -She documented Resident #2's amantadine could not be administered 12/02/19-12/10/19 due to medication "awaiting". -She was not able to administer amantadine to Resident #2 when she worked because it was pending from pharmacy. -She could not remember why it took so long for Resident #2's amantadine to be refilled. -She always contacted the pharmacy via fax to get medications delivered to the facility. -If she could not get the medication refilled, she would notify the Resident Care Coordinator (RCC). -She remembered telling the RCC that the amantadine had not been refilled for Resident #2. -She did not know why it took so long for the pharmacy to deliver the medication.	{D 358}		

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{D 358}	Continued From page 17 -She did not document in the resident's record that she attempted to get the amantadine dispensed. -MAs were responsible for requesting medication refills from the pharmacy when the medications 5 days before running out. Interview with the Resident Care Coordinator (RCC) on 01/02/20 at 3:52pm revealed: -She did not realize Resident #2 missed doses of amantadine in December 2019. -MAs were supposed to request refills from the pharmacy 7 days prior to running out of the medication. -She had notified all MAs that residents under hospice care only received a 15-day supply of medications and they needed to be ordered to prevent residents from running out. -Every few days she tried to pull a missed medication report, however had not noticed that amantadine had not been administered to Resident #2 in December 2019. -She expected MAs to let her know if they were having problems getting medications from the pharmacy timely. Interview with the Administrator on 01/02/20 at 3:54pm revealed: -She expected MAs to order medications 7 days before running out of the medications to ensure that it was in the building before running out. -She felt the MAs always ordered medications timely, she did not know why the amantadine was not delivered timely. -She expected the RCC to run a compliance report daily with all the exceptions to catch medications not administered. Attempted telephone call to Resident #2 mental health provider on 01/02/20 at 4:00pm was	{D 358}		

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{D 358}	Continued From page 18 unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Refer to interview with the RCC on 01/02/19 at 4:00pm. Refer to interview with the Administrator on 01/02/19 at 4:07pm. _____ Interview with the RCC on 01/02/19 at 4:00pm. revealed: -The MAs were responsible for requesting refills on all medications. -The MAs were supposed to notify her when Resident #4's medications were not delivered by the pharmacy. -She was supposed to follow up with the pharmacy to find out why the medication was not delivered. -She had not completed an audit of the medication carts to review what medications were not available. Interview with the Administrator on 01/02/19 at 4:07pm revealed: -The MAs were expected to ensure all medications prescribed for the residents were always in the building. -When the MAs had issues with getting a medication for a resident, they were to report it to the RCC. -She ran medication compliance reports, but the reports did not include all reasons for medications not administered. -The RCC had failed to select all the reasons that medications had not been administered.	{D 358}		