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| THE LANDINGS OF ROCKINGHAM | 2605 SWALLOW ROAD REIDSVILLE, NC 27320 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on April 30, 2024 and May 01, 2024. | D 000 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to administer medication as ordered for 1 of 6 residents observed during the morning medication pass who had orders for an antibiotic and aspirin (#6); and for 1 of 5 sampled residents for record review related to an allergy medication (#4).<br><br>The findings are:<br><br>1. The medication error rate was 6% as evidenced by observation of 2 errors out of 33 opportunities during the 2:00pm medication pass on 04/30/24 and the 8:00am medication pass on 05/01/24.<br><br>Review of Resident #6 's current FL2 dated 05/01/24 revealed diagnoses included unspecified dementia, congestive heart failure, chronic obstructive pulmonary disease, and hyperlipidemia. | D 358 | | |

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| D 358 | Continued From page 1<br><br>a. Review of Resident #6's physician's orders dated 04/26/24 revealed there was an order for doxycycline 100mg (an antibiotic used to treat infection) twice a day.<br><br>Observation of the morning medication pass on 05/01/24 at 9:27am revealed:<br>-The medication aide (MA) removed 9 oral medications from Resident #6 medications packaged in multidose bubble packages and compared the medications displayed on the electronic medication administration record (eMAR).<br>-The MA administered 9 tablets with water to Resident #6.<br>-There was no doxycycline 100mg administered to Resident #6 with the medications.<br>-Doxycycline 100mg was not included in the multidose bubble packages used to prepare Resident #6's medications for administration.<br><br>Review of Resident #6's May 2024 eMAR at 10:55am on 05/01/24 revealed:<br>-There was an entry for doxycycline 100mg scheduled for administration at 8:00am and 8:00pm.<br>-Doxycycline 100mg was documented as administered at 8:00am.<br><br>Observation of medication on hand for Resident #6 on 05/01/24 at 12:45pm revealed:<br>-There were two bingo cards of doxycycline 100mg in the locked controlled substance drawer of the medication cart.<br>-One bingo card had 10 of 10 capsules and the other bingo card had 3 of 10 capsules remaining.<br><br>Interview with the morning MA at 12:27am revealed: | D 358 | | |

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| D 358 | Continued From page 2<br>-Resident #6 had several medications scheduled in the morning.<br>-The MA had prepared medications from two multidose bubble packages sent be the resident's pharmacy.<br>-The facility's policy was to store antibiotics in the locked controlled substance drawer to assist with tracking administration.<br>-When questioned about Resident #6's doxycycline 100mg, she immediately retrieved the antibiotic from the locked controlled substance drawer and stated she had not pulled the medication during the morning medication pass.<br>-She knew Resident #6 had started doxycycline 100mg a couple days ago.<br>-She overlooked doxycycline 100mg listed on the eMAR computer screen as she was checking off the medications for preparation and administration.<br><br>Telephone interview with a representative from Resident #6's pharmacy on 05/01/24 at 3:30pm revealed:<br>-The pharmacy dispensed routine medications for Resident #6 in multidose bubble packages that contained a 1-month supply of medications.<br>-Medications ordered after the monthly cycle fill or antibiotic medications were dispensed in individual bingo cards and not included in the multidose bubble packs of medications.<br>-The pharmacy sent a 10 days supply of doxycycline with the medications delivered on 04/28/24.<br><br>Interview with the Resident Care Coordinator (RCC) on 05/01/24 at 2:00pm revealed:<br>-The MAs were supposed to compare all the medications listed on the eMAR computer screen and check the medications off in the space assigned for medication preparation on the eMAR | D 358 | | |

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as each medication was prepared.
-Resident #6's medications were dispensed to the facility, by an outside pharmacy, in multidose bubble packages that contained a 1-month supply instead of a one week supply unlike residents' one week supply multidose bubble packages sent by the facility's contracted pharmacy.
-The facility's policy was to separate antibiotic medications and store them along with the controlled substances to help track the medications and ensure better compliance with administration.
-The MA just missed the doxycycline 100mg administration.

Interview with Resident #6 on 05/01/24 at 4:00pm revealed:
-She had received an antibiotic a few days ago for her deep coughing.
-She had a lot of medications and did not look at each one individually.
-The MAs kept up with her medicines for her.

Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 05/01/24 at 3:28pm was unsuccessful.

Refer to the interview with the Executive Director (ED) on 05/01/24 at 5:20pm.

b. Review of Resident #6's physician's orders dated 02/09/24 and current FL2 dated 05/01/24 revealed there was an order for aspirin (used to increase circulation) 81mg enteric coated (EC) one tablet once daily.

Observation of the morning medication pass on 05/01/24 at 9:27am revealed:
-The medication aide (MA) removed 9 oral medications from Resident #6 medications

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packaged in multidose bubble packages and compared the medications displayed on the electronic medication administration record (eMAR).
-The MA administered 9 tablets with water to Resident #6.
-There was no aspirin 81mg EC administered to Resident #6 with the medications.
-Doxycycline 100mg was not included in the multidose bubble packages used to prepare Resident #6's medications for administration.

Review of Resident #6's May 2024 eMAR at 10:55am on 05/01/24 revealed:
-There was an entry for aspirin 81mg EC scheduled for administration at 8:00am.
-Aspirin 81mg EC was documented as administered at 8:00am.

Observation of medication on hand for Resident #6 on 05/01/24 at 12:45pm revealed:
-Resident #6's medications were packaged in multidose bubble packages containing a 1-month supply of medications by a pharmacy other than the facility's contracted pharmacy..
-The multidose blister packages were color coded for times of administration (yellow was for am medications).
-Resident #6 had 2 yellow morning multidose bubble packages containing morning medications.
-Aspirin 81mg EC tablets were not included in the morning medications multidose packages for Resident #6's.

Interview with the morning MA at 12:27am revealed:
-Resident #6 had several medications scheduled in the morning.
-The MA had prepared medications from two

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multidose bubble packages sent be the resident's pharmacy.
-She routinely compared the medications ordered on the eMAR one by one to the medications in each multidose bubble using the pharmacy package label.
-Once the medications had been checked off as prepared and administration observed, she clicked ok to document administration on the eMAR.
-The residents' eMARs were generated by the facility's contracted pharmacy based on physician's orders received by the contracted pharmacy.
-Resident #6's medications were not dispensed by the facility's contracted pharmacy.
-Resident #6's chosen pharmacy dispensed the resident's medications in a different multidose bubble package (1-month supply at the time) compared to the facility's contracted pharmacy who dispensed multidose bubble packages (a week at a time).
-The MAs did not enter orders into the computer eMAR system but were responsible to review medication orders compared to medications available for administration and administer the medications as ordered.
-She depended on the resident's pharmacy to package medications as ordered and did not check closely every time she prepared the medications.
-She glanced at the medications listed on the multidose bubble package label as she checked off medications included on the eMAR's morning medications.
-Resident #6 had so many morning medications that one multidose bubble would not hold them all; she checked off medications from 2 multidose bubble packages.
-She overlooked Resident #6's aspirin 81mg EC

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| D 358 | Continued From page 6<br>not being included in the resident's daily morning medications.<br><br>Telephone interview with a representative from Resident #6's pharmacy on 05/01/24 at 3:30pm revealed:<br>-The pharmacy dispensed routine medications for Resident #6 in multidose bubble packages that contained a 1-month supply of medications.<br>-Resident #6's medications were filled from orders transferred to the current chosen pharmacy from an affiliated pharmacy to facilitate providing the medications in a multidose bubble package preferred by the facility.<br>-Resident #6's eMARs were generated by the facility's contracted pharmacy and were not accessible by Resident #6's pharmacy.<br>-The pharmacy depended on the facility or providers to ensure all orders for current medications were sent to the pharmacy.<br>-The pharmacy had not received an order for aspirin 81mg EC for Resident #6.<br><br>Interview with the RCC on 05/01/24 at 4:40pm revealed:<br>-The facility faxed all orders, new FL2s and signed physician's orders to the facility's contracted pharmacy for entering on the residents' eMARs.<br>-The facility's primary care provider (PCP) sent her orders to the residents' pharmacies electronically.<br>-Most of the residents used the facility's contracted pharmacy for the medications.<br>-If a resident used an outside pharmacy for medications, the facility was supposed to make sure all orders, FL2s, signed physician's orders and any order was sent to the outside pharmacy for providing the medication.<br>-The facility did not have a full-time nurse. | D 358 | | |

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-The RCC was responsible for ensuring medications were administered as ordered.
-She tried to do random cart audits for comparing medications on the eMAR to medications available for administration.
-There was no system to do routine audits comparing the medications available for administration to the physician's orders except quarterly pharmacy reviews for medication reviews.
-She did not know Resident #6 had an order for aspirin 81mg EC and the outside pharmacy was not sending the medication in the monthly multidose bubble package.

Interview with Resident #6 on 05/01/24 at 4:00pm revealed:
-She had a lot of medications and did not look at each one individually.
-The MAs kept up with her medicines for her.
-She did not remember if she was supposed to be taking an aspirin 81mg EC tablet daily.

Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 05/01/24 at 3:28pm was unsuccessful.

Refer to the interview with the Executive Director (ED) on 05/01/24 at 5:20pm.

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Interview with the Executive Director on 05/01/24 at 5:15pm revealed:
-The Resident Care Director (RCC) and the MAs were responsible for processing medication orders and ensuring medications were administered as ordered.
-The contracted pharmacy was supposed to receive all medications orders and enter the orders on the residents' eMARs.
-The RCC reviewed medication orders and

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released the orders for the MAs to start administering medications.
-She was not routinely involved in monitoring residents' medication administration.

3. Review of Resident #4's current FL2 dated 09/26/23 revealed:
-Diagnoses included hypertension, hyperlipidemia, hypothyroidism, bipolar, diabetes mellitus, chronic obstructive pulmonary disease (COPD), heart disease, and brain hemorrhage.
-There was an order for fluticasone propionate (a medication used to treat seasonal allergies) 50 mcg two sprays in each nostril daily.

Review of Resident #4's signed physician's orders dated 12/12/23 revealed an order for fluticasone propionate 50mcg spray two sprays in each nostril daily.

Review of Resident #4's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for fluticasone propionate spray 50mcg two sprays in each nostril daily with a scheduled administration time of 10:00am
-Fluticasone propionate 50mcg spray was documented as administered daily from 02/01/24 to 02/29/24.

Review of Resident #4's March 2024 eMAR revealed:
-There was an entry for fluticasone propionate spray 50mcg two sprays in each nostril daily with a scheduled administration time of 10:00am
-Fluticasone propionate 50mcg spray was documented as administered daily from 03/01/24 to 03/31/24.

Review of Resident #4's April 2024 eMAR

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revealed:
-There was an entry for fluticasone propionate spray 50mcg two sprays in each nostril daily with a scheduled administration time of 10:00am
-Fluticasone propionate 50mcg spray was documented as administered daily from 04/01/24 to 04/31/24.

Observation of medications on hand for Resident #4 on 05/01/24 at 3:10pm revealed:
-There was one bottle of fluticasone propionate 50mcg nasal spray available for administration.
-The bottle had not been opened; the seal was still intact.
-There was no other fluticasone propionate 50mcg nasal spray available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 05/01/24 at 3:24pm revealed:
-One bottle of fluticasone propionate 50mcg nasal spray was dispensed on 02/16/24.
-One bottle of fluticasone propionate 50mcg nasal spray was dispensed on 05/18/23.
-The fluticasone propionate was not part of the facility's cycle fill schedule; the facility staff would have to call the pharmacy to reorder.
-One bottle of fluticasone propionate nasal spray 50mcg would typically last for thirty days.
-Fluticasone propionate nasal spray was used for allergies.
-If the resident did not receive the medication as ordered, it could result in increased allergic symptoms like runny or stuffy nose.

Interview with a medication aide (MA) on 05/01/24 at 3:30pm revealed:
-Resident #4 did get nasal spray daily.
-Resident #4 never refused her medications.
-She had not noticed increased allergy symptoms

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for Resident #4.
-She did not know why the bottle of fluticasone propionate nasal spray that was on the medication cart was unopened.
-There was no other fluticasone propionate nasal spray available for Resident #4.

Attempted telephone interview with Resident #4's primary care provider (PCP) on 05/01/24 at 3:43pm was unsuccessful.

Interview with Resident #4 on 05/01/24 at 4:15pm revealed:
-She had a headache.
-She had allergy symptoms including runny or stuffy nose and headaches.
-She did not receive any nasal spray for her allergies.
-Her allergies were bothering her and she could use some nasal spray to help.

Interview with the Resident Care Coordinator (RCC) on 05/01/24 at 4:20pm revealed:
-She was not aware Resident #4 had a bottle of fluticasone nasal spray that was unopened.
-She did not know how the fluticasone nasal spray could be administered if the bottle was unopened.
-She checked the eMAR's and compared them to the medications on the medication cart.
-The night shift MA started checking the medication carts in January 2024 but they were not doing it correctly if there were errors.
-She did not check the medications on the medication cart for dispense dates and whether medications that were not on cycle fill were being used as ordered.

Interview with the Administrator on 05/01/24 at 4:50pm revealed:

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| D 358 | Continued From page 11<br>-The RCC was responsible for making sure medications were available and being used as ordered.<br>-She was concerned that Resident #4's fluticasone propionate nasal spray was unopened on the medication cart and Resident #4 was not receiving the medication as ordered.<br>-She expected MA's to give medications as ordered. | D 358 | | |
| D 367 | 10A NCAC 13F .1004(j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;<br>(6) date and time of administration;<br>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,<br>(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure the accuracy | D 367 | | |

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of the electronic medication administration record (eMAR) for 1 of 6 (#6) residents observed during medication administration related to medications for bladder control and cholesterol.

The findings are:

Review of Resident #6 's current FL2 dated 05/01/24 revealed diagnoses included unspecified dementia, congestive heart failure, chronic obstructive pulmonary disease, and hyperlipidemia.

1. Review of Resident #6's physician's order dated 04/18/24 revealed an order for solifenacin 5mg once daily for bladder incontinence.

Observation of the morning medication pass on 05/01/24 at 9:27am revealed:
-The medication aide (MA) removed 9 oral medications from Resident #6 medications packaged in yellow multidose bubble packages and compared the medications displayed on the electronic medication administration record (eMAR).
-The MA administered 9 tablets with water to Resident #6.
-There was no solifenacin 5mg administered to Resident #6 with the medications.
-Solifenacin 5mg was not included in the yellow multidose bubble packages used to prepare Resident #6's medications for administration.

Interview with the MA on 05/01/24 at 9:28am revealed:
-Resident #6's medications were dispensed from an outside pharmacy not the facility's contracted pharmacy.
-Resident #6's pharmacy pre-packed the residents' medication in multidose bubble

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packages that contained a 1- month's supply of medication.
-The multidose bubble packages were color coded and yellow packages were for morning medication administration; blue packages were for evening administration.

Review of Resident #6's May 2024 eMAR revealed:
-There was an entry for solifenacin 5mg once daily scheduled for administration at 8:00am.
- Solifenacin 5mg was documented administered at 8:00am on 05/01/24.

Review of Resident #6's April 2024 eMAR revealed:
-There was an entry for solifenacin 5mg once daily scheduled for administration at 8:00am.
- Solifenacin 5mg was documented administered at 8:00am from 04/19/24 to 04/30/24.

Observation of medication on hand for Resident #6 on 05/01/24 at 12:13pm revealed:
-There was a blue (used to designate evening administration) multidose bubble package labeled 8:00pm with 4 medications, including one solifenacin 5mg packaged for administration at 8:00pm.
-The package was labeled with dates from 05/04/24 to 06/03/24.
-The multidose bubble package labeled 06/03/24 was empty.

Interview with the morning MA at 12:27am revealed:
-Resident #6 had several medications scheduled in the morning.
-The residents' eMARs were generated by the facility's contracted pharmacy based on physician's orders received by the contracted

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| D 367 | Continued From page 14<br>pharmacy.<br>-Resident #6's medications were not dispensed by the facility's contracted pharmacy.<br>-Resident #6's pharmacy dispensed the resident's medications in a different multidose bubble package (a 1-month supply at the time) compared to the facility's contracted multidose bubble packages (a week at a time). (Thought it was a 1-month supply)<br>-The MAs did not enter orders into the computer eMAR system, but were responsible to review medication orders compared to medications available for administration and administer the medications as ordered.<br>-She depended on the resident's pharmacy to package medications as ordered and did not check closely every time she prepared the medications.<br>-She glanced at the medications listed on the multidose bubble package label as she checked off medications included on the eMAR's morning medications.<br>-Resident #6 had so many morning medications that one multidose bubble package would not hold them all; she checked off medications from 2 multidose bubble packages.<br>-She did not routinely look at the evening (blue) multidose bubble packages, because they were not for routine administration during her 7:00am to 3:00pm shift.<br>-All the medications packaged in the evening multidose bubble were packaged for 8:00pm administration by Resident #6's pharmacy.<br><br>Telephone interview with a representative from Resident #6's pharmacy on 05/01/24 at 3:40pm revealed:<br>-The pharmacy did not generate the facility's eMARs and did not have computer access to the information displayed on the facility's eMAR. | D 367 | | |

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| D 367 | Continued From page 15<br>-The pharmacy prepared Resident #6's medications in multidose bubble packages per the facility's request.<br>-The pharmacy had an order for one daily solifenacin 5mg for bladder incontinence and packaged it for a 1-month supply during the last week of April 2024 for the facility to have on hand for administration in May 2024.<br>-The facility would be responsible to contact Resident #6's pharmacy for package changes or the pharmacy generating the eMAR to ensure administration times packaged were the same as times documented for administration on the eMAR.<br><br>Interview with Resident #6 on 05/01/24 at 4:00pm revealed:<br>-She had a lot of medications and did not look at each one individually.<br>-The medication staff kept up with her medicines for her.<br><br>Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 05/01/24 at 3:28pm was unsuccessful.<br><br>Refer to the interview with the Resident Care Coordinator (RCC) on 05/01/24 at 4:40pm.<br><br>Refer to the interview with the Executive Director (ED) on 05/01/24 at 5:20pm.<br><br>2. Review of Resident #6's physician's order dated 04/18/24 revealed an order for simvastatin 20mg (used to treat high cholesterol) take one tablet daily at bedtime.<br><br>Observation of the morning medication pass on 05/01/24 at 9:27am revealed:<br>-The medication aide (MA) removed 9 oral | D 367 | | |

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medications from Resident #6 medications packaged in yellow multidose bubble packages and compared the medications displayed on the electronic medication administration record (eMAR).
-The MA administered 9 tablets with water to Resident #6.
-There was no simvastatin 20mg administered to Resident #6 with the medications.
-Simvastatin 20mg was not included in the yellow multidose bubble packages used to prepare Resident #6's medications for administration.

Interview with the MA on 05/01/24 at 9:28am revealed:
-Resident #6's medications were dispensed from an outside pharmacy not the facility's contracted pharmacy.
-Resident #6's pharmacy pre-packed the residents' medication in multidose bubble packages that contained a 1-month's supply of medication.
-The multidose bubble packages were color coded and yellow packages were for morning administration; blue packages were for evening administration.

Observation of medication on hand for Resident #6 on 05/01/24 at 12:13pm revealed:
-There was a blue (used to designate evening administration) multidose bubble package labeled 8:00pm with 4 medications, including one simvastatin 20mg tablet, packaged for administration at 8:00pm.
-The package was labeled with dates from 05/04/24 to 06/03/24.
-The multidose bubble labeled 06/03/24 was empty.

Review of Resident #6's May 2024 eMAR on

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| D 367 | Continued From page 17<br>05/01/24 revealed:<br>-There was an entry for simvastatin 20mg once daily scheduled for administration at 8:00am.<br>-Simvastatin 20mg was documented administered at 8:00am on 05/01/24.<br><br>Review of Resident #6's April 2024 eMAR revealed:<br>-There was an entry for simvastatin 20mg once daily scheduled for administration at 8:00am.<br>-Simvastatin 20mg was documented administered at 8:00am on 04/01/24 to 04/30/24.<br><br>Telephone interview with a representative from Resident #6's pharmacy on 05/01/24 at 3:40pm revealed:<br>-The pharmacy did not generate the facility's eMARs and did not have computer access to the information displayed on the facility's eMAR.<br>-The pharmacy prepared Resident #6's medications in multidose bubble packages per the facility's request.<br>-The pharmacy had an order for one daily simvastatin 20mg and packaged it in the 8:00pm medications (blue package) for a 1-month supply during the last week of March 2024 for administration in April 2024 and the last week of April 2024 for the facility to have on hand for administration in May 2024.<br>-The facility would be responsible to contact Resident #6's pharmacy for package changes, or the pharmacy generating the eMAR, to ensure administration times packaged were the same as times documented for administration on the eMAR.<br><br>Interview with Resident #6 on 05/01/24 at 4:00pm revealed:<br>-She had a lot of medications and did not look at each one individually. | D 367 | | |

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| D 367 | Continued From page 18<br>-The MAs kept up with her medicines for her.<br><br>Attempted telephone interview with Resident #6's Primary Care Provider (PCP) on 05/01/24 at 3:28pm was unsuccessful.<br><br>Refer to the interview with the morning medication aide (MA) on 05/01/24 at 12:27am.<br><br>Refer to the interview with the Resident Care Coordinator (RCC) on 05/01/24 at 4:40pm.<br><br>Refer to the interview with the Executive Director (ED) on 05/01/24 at 5:20pm.<br><br>_____<br>Interview with the morning MA on 05/01/24 at 12:27am revealed:<br>-Resident #6 had several medications scheduled in the morning.<br>-The residents' eMARs were generated by the facility's contracted pharmacy based on physician's orders received by the contracted pharmacy.<br>-Resident #6's medications were not dispensed by the facility's contracted pharmacy.<br>-Resident #6's pharmacy dispensed the resident's medications in different multidose bubble packages (a 1-month supply at the time) compared to the facility's contracted multidose bubble packages (a week at a time). (Thought it was monthly)<br>-The MAs did not enter orders into the computer eMAR system but were responsible to review medication orders compared to medications available for administration and administer the medications as ordered.<br>-She depended on the resident's pharmacy to package medications as ordered and did not check closely every time she prepared the medications. | D 367 | | |

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| D 367 | Continued From page 19<br>-She glanced at the medications listed on the multidose bubble package labels as she checked off medications included on the eMAR's morning medications.<br>-Resident #6 had so many morning medications that one multidose bubble would not hold them all; she checked off medications from 2 multidose bubble packages.<br>-She did not routinely look at the evening (blue) multidose bubble packages, because they were not for routine administration during her 7:00am to 3:00pm shift.<br>-All the medications packaged in the evening multidose bubble were packaged for 8:00pm administration by Resident #6's pharmacy.<br><br>Interview with the RCC on 05/01/24 at 4:40pm revealed:<br>-The RCC was responsible for ensuring eMAR documentation was accurate.<br>-The facility faxed all orders, new FL2s and signed physician's orders to the facility's contracted pharmacy for placing on the residents' eMARs and to outside pharmacies for supplying medications in the event a resident used an outside pharmacy for medications.<br>-She tried to do random cart audits for comparing medications on the eMAR to medications available for administration.<br>-There was no system to do routine audits comparing the medications available for administration to the physician's orders except quarterly pharmacy reviews for medication reviews.<br>-She did not know Resident #6 had medications packaged for administration at 8:00pm daily by Resident #6's pharmacy, but documented as administered at 8:00am daily on the eMAR generated by the facility's contracted pharmacy.<br>-She did not have a system in place to routinely | D 367 | | |

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| D 367 | Continued From page 20<br>audit eMAR documentation compared to the residents' medication orders.<br><br>Interview with the ED on 05/01/24 at 5:15pm revealed:<br>-The contracted pharmacy was supposed to receive all medications orders and enter the orders on the residents' eMARs.<br>-The RCC reviewed medication orders and released the orders for the MAs to start administering medications.<br>-The RCC and the MAs were responsible for processing medication orders and ensuring medications were administered as ordered and all documentation of administration was accurate.<br>-She was not routinely involved in monitoring residents' medication administration. | D 367 | | |