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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCLAVE AT SILKGRASS	118 SILKGRASS WAY CLAYTON, NC 27527

(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
C 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 05/15/25.	C 000		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that medication orders were clarified for 2 of 3 sampled residents (#2, #3) including a topical medication for inflammatory skin conditions (#2), an antidepressant (#3), a medication for Alzheimer's dementia (#3), and a probiotic for gut health (#3). The findings are: 1. Review of Resident #2's current FL-2 dated 04/25/25 revealed: -Diagnoses included multiple sclerosis, mild cognitive impairment, and bipolar disorder. -There was an order for Mirvaso 0.33% Gel Pump, apply a pea-sized amount topically to the	C 315		

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affected area once a day for rosacea (inflammatory skin conditions that cause redness and bumps on the face). (Mirvaso is used to treat facial skin affected by redness due to rosacea.)
-There was a handwritten note beside the order for Mirvaso with the words, "never prescribed" but there was no signature, initials, or date to indicate who wrote the note.

Review of Resident #2's primary care provider (PCP) orders dated 04/17/25 revealed:
-There was a section on the order form to list any medications to discontinue.
-Mirvaso 0.33% Gel was listed under the discontinue section but marked through with a line and the PCP's initials.
-Mirvaso 0.33% Gel was not listed in the medication order section of the form.

Review of Resident #2's physician's orders and progress notes revealed no documentation the PCP had been contacted to clarify if the resident was to be administered Mirvaso 0.33% Gel.

Review of Resident #2's April 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Mirvaso 0.33% Gel Pump, apply a pea-sized amount topically to affected area once daily for rosacea scheduled at 8:00am.
-Mirvaso was documented as not being administered from 04/01/25 - 04/18/25 due to "waiting on pharmacy" and/or "not on cart".
-Mirvaso was documented as administered from 04/19/25 - 04/30/25.

Review of Resident #2's May 2025 eMAR for 05/01/25 - 05/15/25 revealed:
-There was an entry for Mirvaso 0.33% Gel

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C 315	Continued From page 2 Pump, apply a pea-sized amount topically to affected area once daily for rosacea scheduled at 8:00am. -Mirvaso was documented as administered from 05/01/25 - 05/15/25. Observation of Resident #2's medications on hand on 05/15/25 at 1:15pm revealed there was no Mirvaso 0.33% Gel available for administration. Interview with the medication aide (MA) on 05/15/25 at 1:15pm revealed: -Resident #2 did not use the facility's contracted pharmacy. -The resident used an outside pharmacy. -The MA did not answer when asked if the resident received Mirvaso Gel that morning at 8:00am as documented on the eMAR. Interview with the Facility Manager (FM) on 05/15/25 at 1:30pm revealed: -Resident #2 received the Mirvaso Gel that morning, 05/15/25. -The resident's power of attorney (POA) came to the facility that morning and picked up the Mirvaso Gel because the POA did not want the resident to be using the medication. -She thought the PCP was going to discontinue the Mirvaso Gel, but she did not have an order to discontinue it yet. Observation of Resident #2 on 05/15/25 at 9:56am revealed: -The resident was sitting in the dining room. -The resident's facial cheeks were light pink with no redness. Interview with Resident #2 on 05/15/25 at 9:56am revealed:	C 315		

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-She used an outside pharmacy for her medications.
-She was not aware of the facility running out of any of her medications.
-She had cream for her face, but she refused it sometimes because it made her face sting.
-She did not know the names of the creams for her face.

Telephone interview with a pharmacist at Resident #2's outside pharmacy provider on 05/15/25 at 3:47pm revealed:
-They were the primary pharmacy for dispensing Resident #2's medications.
-They did not provide eMARs to the facility.
-They never received an order for Mirvaso 0.33% Gel for Resident #2; therefore, they never dispensed any Mirvaso 0.33% Gel for the resident.

Telephone interview with Resident #2's POA on 05/15/25 at 3:22pm revealed:
-Resident #2 used an outside pharmacy for medications.
-The facility staff was responsible for ordering the resident's medications from the outside pharmacy.
-The outside pharmacy usually delivered the medications to the facility.
-The facility staff needed to let her know if the pharmacy did not send the medications needed by the resident.
-No one at the facility had contacted her about the resident being out of any medications.
-She had not visited the facility yet today, so she had not picked up any medications for Resident #2 from the facility today, 05/15/25.
-Resident #2 was not supposed to be getting Mirvaso Gel.
-The resident tried it a while back and it did not

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work so she told the facility staff not to order the medication.

Second interview with the FM on 05/15/25 at 4:30pm revealed:
-The facility's Administrator was unavailable for interview.
-New medication orders, including discontinue orders, should be given to her and she sent them to the pharmacy.
-The facility's contracted pharmacy usually entered orders into the eMAR system.
-She had to review and approve the orders prior to the orders becoming active in the eMAR system.
-She usually checked the eMARs every day for accuracy.
-She and the Resident Coordinator (RC) were responsible for doing medication order clarifications.
-She thought she had contacted the resident's outside pharmacy about Resident #2's face gel and she thought the pharmacy staff told her they were waiting on the PCP or the POA to see if they wanted the medication to be dispensed.
-She did not document when she contacted the pharmacy.

Telephone interview with the RC on 05/15/25 at 6:08pm revealed:
-She or the FM were responsible for clarifying orders.
-She was not aware of the discrepancy with Resident #2's Mirvaso 0.33% Gel order.

Telephone interview with a medical assistant at Resident #2's PCP's office on 05/15/25 at 4:00pm revealed:
-The PCP was unavailable for interview.
-The PCP first prescribed Mirvaso 0.33% Gel for

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Resident #2 in December 2024.
-The notes in their records indicated the Mirvaso 0.33% Gel should have been discontinued in January 2025 due to the high cost of the medication.
-There was no documentation the facility had contacted the PCP's office to clarify the order for Mirvaso Gel.

2. Review of Resident #3's current FL-2 dated 04/09/25 revealed diagnosis included dementia.

a. Review of Resident #3's current FL-2 dated 04/09/25 revealed:
-There was an order for Acidophilus 175mg 1 capsule daily. (Acidophilus is a probiotic used for gut health.)
-There was an order for Donepezil 5mg 1 tablet at bedtime. (Donepezil is used to treat Alzheimer's dementia.)

Review of Resident #3's current hospice orders dated 04/30/25 revealed:
-There was no order listed for Resident #3 to receive Acidophilus.
-There was no order listed for Resident #3 to receive Donepezil.

Review of Resident #3's physician's orders and progress notes revealed no documentation the resident's hospice provider had been contacted to clarify if the resident was supposed to receive Acidophilus and Donepezil.

Review of Resident #3's April 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Acidophilus 175mg 1 capsule daily scheduled for 8:00am.
-Acidophilus was documented as administered

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daily from 04/01/25 - 04/30/25.
-There was an entry for Donepezil 5mg 1 tablet at bedtime scheduled for 8:00pm.
-Donepezil was documented as administered daily from 04/01/25 - 04/30/25.

Review of Resident #3's May 2025 eMAR for 05/01/25 - 05/15/25 revealed:
-There was an entry for Acidophilus 175mg 1 capsule daily scheduled for 8:00am.
-Acidophilus was documented as administered daily from 05/01/25 - 05/15/25.
-There was an entry for Donepezil 5mg 1 tablet at bedtime scheduled for 8:00pm.
-Donepezil was documented as administered daily from 05/01/25 - 05/14/25.

Observation of Resident #3's medications on hand on 05/15/25 at 1:33pm revealed:
-There was a supply of Acidophilus capsules dispensed on 05/06/25 with instructions to take 1 capsule every day.
-There were 21 of 30 capsules remaining.
-There was a supply of Donepezil 5mg tablets dispensed on 05/06/25 with instructions to take 1 tablet at bedtime.
-There were 22 of 30 tablets remaining.

Interview with the Resident Coordinator (RC) on 05/15/25 at 2:10pm revealed:
-She was responsible for clarifying medication orders.
-She had not noticed Acidophilus and Donepezil were not listed in the current hospice orders for Resident #3.

Telephone interview with the patient care manager at Resident #3's hospice provider on 05/15/25 at 3:03pm revealed:
-Resident #3 had recently started to decline in

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health so she was not receiving a lot of medications.
-The hospice provider did not typically keep hospice residents on medications like Acidophilus and Donepezil.
-Resident #3's Acidophilus and Donepezil were discontinued on 03/28/25.
-No one at the facility had contacted them to clarify whether the resident was supposed to receive Acidophilus or Donepezil.

b. Review of Resident #3's mental health provider (MHP) visit note dated 04/22/25 revealed:
-The resident had dementia that was progressing with some agitation and irritability that comes and goes.
-The resident had depression that was intermittently unstable with some sadness that comes and goes.
-There was an order to continue Sertraline 100mg 1 tablet daily. (Sertraline is an antidepressant.)

Review of Resident #3's current hospice orders dated 04/30/25 revealed there was no order for Resident #3 to receive Sertraline.

Review of Resident #3's physician's orders and progress notes revealed no documentation the hospice provider or the MHP had been contacted to clarify if the resident was to be administered Sertraline.

Review of Resident #3's April 2025 electronic medication administration record (eMAR) revealed there was no entry for Sertraline 100mg and none was documented as administered for April 2025.

Review of Resident #3's May 2025 eMAR for 05/01/25 - 05/15/25 revealed there was no entry

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C 315	Continued From page 8 for Sertraline 100mg and none was documented as administered for May 2025. Observation of Resident #3's medications on hand on 05/15/25 at 1:33pm revealed there was no Sertraline available for administration. Interview with the Resident Coordinator (RC) on 05/15/25 at 2:10pm revealed: -She was responsible for clarifying medication orders. -She thought Resident #3 had been discharged from the MHP's services due to resident receiving hospice services. -She went by the hospice orders for Resident #3, not the MHP orders. -She did not clarify the orders with the MHP or the hospice provider. Telephone interview with the patient care manager at Resident #3's hospice provider on 05/15/25 at 3:03pm revealed: -She would not have any knowledge of what medications the resident's MHP provider had prescribed. -Sertraline was not listed on the resident's hospice medication orders. -No one at the facility had contacted them to clarify whether the resident was to receive Sertraline. Attempted telephone interview with Resident #3's MHP on 05/15/25 at 2:59pm was unsuccessful.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the	C 330		

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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:
FOLLOW-UP TO TYPE B VIOLATION.

The Type B Violation was abated.
Non-compliance continues.

Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents (#2) sampled including errors with a topical medication for inflammatory skin conditions and a vitamin supplement.

The findings are:

Review of Resident #2's current FL-2 dated 04/25/25 revealed:
-Diagnoses included multiple sclerosis, mild cognitive impairment, and bipolar disorder.
-There was an order for Azelaic Acid 15% Gel, after skin is washed and dried, apply typically 2 times a day and massage a thin film into affected area in the morning and evening. (Azelaic Acid is used to treat rosacea and acne. Rosacea and acne are inflammatory skin conditions that cause redness and bumps on the face.)
-There was an order for Folic Acid 1mg 1 tablet once daily. (Folic Acid is a B vitamin used to treat and prevent folate deficiency anemia.)

Review of Resident #2's April 2025 electronic

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medication administration record (eMAR) revealed:
-There was an entry for Azelaic Acid 15% Gel, after skin is washed and dried, apply typically 2 times a day and massage a thin film into affected area in the morning and evening.
-Azelaic Acid 15% Gel was scheduled for 8:00am and 6:00pm.
-Azelaic Acid was documented as not being administered from 8:00am on 04/01/25 - 8:00am on 04/18/25 due to "waiting on pharmacy" and/or "not on cart".
-Azelaic Acid was documented as administered from 6:00pm on 04/18/25 - 6:00pm on 04/30/25.
-There was an entry for Folic Acid 1mg 1 tablet once a day scheduled at 8:00am.
-Folic Acid was documented as not being administered from 04/01/25 - 04/18/25 due to "waiting on pharmacy" and/or "not on cart".
-Folic Acid was documented as administered from 04/19/25 - 04/30/25.

Review of Resident #2's May 2025 eMAR for 05/01/25 - 05/15/25 revealed:
-There was an entry for Azelaic Acid 15% Gel, after skin is washed and dried, apply typically 2 times a day and massage a thin film into affected area in the morning and evening.
-Azelaic Acid 15% Gel was scheduled for 8:00am and 6:00pm.
-Azelaic Acid was documented as administered 16 occasions from 05/01/25 - 05/15/25.
-Azelaic Acid was documented as being refused on 12 occasions from 05/01/25 - 05/15/25.
-There was an entry for Folic Acid 1mg 1 tablet once a day scheduled at 8:00am.
-Folic Acid was documented as administered from 05/01/25 - 05/15/25.

Observation of Resident #2's medications on

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hand on 05/15/25 at 1:15pm revealed:
-There was a tube of Azelaic Acid 15% Gel dispensed on 04/17/25.
-The instructions were to apply topically twice a day after skin is thoroughly washed and patted dry, gently but thoroughly massage a thin film to the affected area twice daily, in the morning and evening.
-There was a bottle of Folic Acid 1mg tablets dispensed on 04/17/25.
-The instructions were to take 1 tablet daily.
-There were 4 of 30 Folic Acid 1mg tablets remaining.

Interview with the medication aide (MA) on 05/15/25 at 1:15pm revealed:
-Resident #2 did not use the facility's contracted pharmacy.
-The resident used an outside pharmacy.
-Resident #2 did not receive Azelaic Acid 15% Gel and Folic Acid in April 2025 because the resident's power of attorney (POA) was waiting on the outside pharmacy to dispense the medication.
-She was not aware of a back-up plan to get medication not received from an outside pharmacy.

Observation of Resident #2 on 05/15/25 at 9:56am revealed:
-The resident was sitting in the dining room.
-The resident's facial cheeks were light pink with no redness.

Interview with Resident #2 on 05/15/25 at 9:56am revealed:
-She used an outside pharmacy for her medications.
-She was not aware of the facility running out of any of her medications.

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C 330	Continued From page 12 -She had cream for her face, but she refused it sometimes because it made her face sting. -She was not sure which vitamins she received. Telephone interview with a pharmacist at Resident #2's pharmacy provider on 05/15/25 at 3:47pm revealed: -They were the primary pharmacy for dispensing Resident #2's medications. -They did not provide eMARs to the facility. -They received the order dated 04/17/25 for Azelaic Acid for Resident #2 on 04/17/25. -They dispensed Azelaic Acid 15% Gel for Resident #2 on 04/17/25 and delivered it to the facility on 04/18/25. -They had previously dispensed Azelaic Acid for Resident #2 on 01/02/25 and 02/15/25. -They received the order dated 04/17/25 for Folic Acid for Resident #2 on 04/17/25. -They dispensed Folic Acid 1mg tablets for Resident #2 on 04/17/25 and delivered them to the facility on 04/18/25. Telephone interview with Resident #2's POA on 05/15/25 at 3:22pm revealed: -Resident #2 used an outside pharmacy for medications. -The facility staff was responsible for ordering the resident's medications from the outside pharmacy. -The outside pharmacy usually delivered the medications to the facility. -The facility staff needed to let her know if the pharmacy did not send the medications needed by the resident. -No one at the facility had contacted her about the resident being out of any medications. -She was not aware the resident was out of medications in April 2025.	C 330		

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	FCL051069	A. BUILDING: _____ B. WING _____	R 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ENCLAVE AT SILKGRASS	118 SILKGRASS WAY CLAYTON, NC 27527

(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
C 330	Continued From page 13 Interview with the Facility Manager (FM) on 05/15/25 at 4:30pm revealed: -The facility's Administrator was unavailable for interview. -The MAs should not document a medication was administered on the eMAR if there was no medication available to administer. -She usually checked the eMARs every day for accuracy. -The MAs should notify her if medications were unavailable. -Resident #2's outside pharmacy usually sent medications to the facility automatically. -She thought she had contacted the resident's outside pharmacy about the resident's medications in April 2025 but she did not document when she contacted the pharmacy. Telephone interview with the Resident Coordinator (RC) on 05/15/25 at 6:08pm revealed: -The FM was responsible for reviewing eMARs monthly for accuracy. -The MAs should notify her or the FM if medications were unavailable. Telephone interview with a medical assistant at Resident #2's primary care provider (PCP) office on 05/15/25 at 4:00pm revealed: -The PCP was unavailable for interview. -The PCP prescribed Azelaic Acid 15% Gel for Resident #2 in December 2024, January 2025, and April 2025. -The Azelaic Acid 15% Gel was prescribed to treat the resident's rosacea. -The PCP first prescribed Folic Acid for Resident #2 on 04/17/25. -There were no orders for Folic Acid for Resident #2 prior to 04/17/25. -She did not know why Folic Acid would be on the	C 330		

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C 330	Continued From page 14 resident's MAR prior to 04/17/25. -There was no documentation in their records of being notified by the facility that the resident missed any doses of the Azelaic Acid or Folic Acid in April 2025.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (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). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#2) including inaccurate documentation for a topical medication used to treat inflammatory skin conditions.	C 342		

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C 342	Continued From page 15 The findings are: Review of Resident #2's current FL-2 dated 04/25/25 revealed: -Diagnoses included multiple sclerosis, mild cognitive impairment, and bipolar disorder. -There was an order for Mirvaso 0.33% Gel Pump, apply a pea-sized amount topically to the affected area once a day for rosacea (inflammatory skin conditions that cause redness and bumps on the face). (Mirvaso is used to treat facial skin affected by redness due to rosacea.) -There was a handwritten note beside the order for Mirvaso with the words, "never prescribed" but there was no signature, initials, or date to indicate who wrote the note. Review of Resident #2's primary care provider (PCP) orders dated 04/17/25 revealed: -There was a section on the order form to list any medications to discontinue. -Mirvaso 0.33% Gel was listed under the discontinue section but marked through with a line and the PCP's initials. -Mirvaso 0.33% Gel was not listed in the medication order section of the form. Review of Resident #2's physician's orders and progress notes revealed no documentation the PCP had been contacted to clarify if the resident was to be administered Mirvaso 0.33% Gel. Review of Resident #2's April 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Mirvaso 0.33% Gel Pump, apply a pea-sized amount topically to affected area once daily for rosacea scheduled at 8:00am.	C 342		

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C 342	Continued From page 16 -Mirvaso was documented as not being administered from 04/01/25 - 04/18/25 due to "waiting on pharmacy" and/or "not on cart". -Mirvaso was documented as administered from 04/19/25 - 04/30/25. Review of Resident #2's May 2025 eMAR for 05/01/25 - 05/15/25 revealed: -There was an entry for Mirvaso 0.33% Gel Pump, apply a pea-sized amount topically to affected area once daily for rosacea scheduled at 8:00am. -Mirvaso 0.33% Gel was documented as administered from 05/01/25 - 05/15/25. Observation of Resident #2's medications on hand on 05/15/25 at 1:15pm revealed there was no Mirvaso 0.33% Gel available for administration. Interview with the medication aide (MA) on 05/15/25 at 1:15pm revealed: -Resident #2 did not use the facility's contracted pharmacy. -The resident used an outside pharmacy. -She could not locate any Mirvaso 0.33% Gel for the resident. -The MA did not answer when asked if the resident received Mirvaso 0.33% Gel that morning at 8:00am as documented on the eMAR. Interview with the Facility Manager (FM) on 05/15/25 at 1:30pm revealed: -The resident received the Mirvaso 0.33% Gel that morning, 05/15/25. -The resident's power of attorney (POA) came to the facility that morning and picked up the Mirvaso 0.33% Gel because the POA did not want the resident to be using the medication. -She thought the PCP was going to discontinue	C 342		

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C 342	Continued From page 17	C 342		

the Mirvaso Gel but she did not have an order to discontinue it yet.

Interview with Resident #2 on 05/15/25 at 9:56am revealed:
-She used an outside pharmacy for her medications.
-She was not aware of the facility running out of any of her medications.
-She had cream for her face, but she refused it sometimes because it made her face sting.
-She did not know the names of the creams for her face.

Telephone interview with a pharmacist at Resident #2's pharmacy provider on 05/15/25 at 3:47pm revealed:
-They were the primary pharmacy for dispensing Resident #2's medications.
-They did not provide eMARs to the facility.
-They never received an order for Mirvaso 0.33% Gel for Resident #2; therefore, they never dispensed any Mirvaso 0.33% Gel for the resident.

Telephone interview with Resident #2's POA on 05/15/25 at 3:22pm revealed:
-Resident #2 used an outside pharmacy for medications.
-The facility staff was responsible for ordering the resident's medications from the outside pharmacy.
-The outside pharmacy usually delivered the medications to the facility.
-The facility staff needed to let her know if the pharmacy did not send the medications needed by the resident.
-No one at the facility had contacted her about the resident being out of any medications.
-She had not visited the facility yet today, so she

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C 342	Continued From page 18 had not picked up any medications for Resident #3 from the facility today, 05/15/25. -Resident #3 was not supposed to be getting Mirvaso 0.33% Gel. -She tried it a while back (could not recall how long ago) and it did not work so she told the facility staff not to order the medication. Second interview with the FM on 05/15/25 at 4:30pm revealed: -The facility's Administrator was unavailable for interview. -The facility's contracted pharmacy usually entered orders into the eMAR system. -She had to review and approve the orders prior to the orders becoming active in the eMAR system. -She usually checked the eMARs every day for accuracy. -The MAs should not document a medication was administered on the eMAR if there was no medication available to administer. Telephone interview with the Resident Coordinator (RC) on 05/15/25 at 6:08pm revealed: -She was not aware of the discrepancy with Resident #2's Mirvaso 0.33% Gel order. -The MAs should not document a medication was administered on the eMAR when the medication was unavailable.	C 342		