STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675112	A. Building B. Wing	04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Rehabilitation and Nursing of Arlington	1112 Gibbins Rd Arlington, TX 76011

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28637 Based on interviews and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident for five (Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5) of five residents reviewed for pharmacy services. The facility failed to ensure that documentation of narcotic medications signed out on the narcotic count sheet were consistent with documentation of narcotic medications administered to Resident #1, Resident #2, Resident #3, Resident #4, and Resident #5 as reflected on their MAR and nursing progress notes. These failures could place residents at risk for medication errors, potentially leading to overdose of narcotic pain medications, or diversion of narcotic pain medications. Findings included: 1) Record review of Resident #1's Admission Record dated 4/23/25 reflected a [AGE] year-old female initially admitted to the facility om 12/23/24 and readmitted on [DATE]. Record review of Resident #1's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 5 indicating severe cognitive impairment. Her diagnoses included hypertension (high blood pressure); Multi-drug resistant organism (an infection resistant to many types of antibiotics); stroke; non-Alzheimer's dementia (neurodegenerative disease causing dementia that is not Alzheimer's disease); and inflammatory spondylopathy lumbar region (autoimmune disease that affects the spine and surrounding joints causing inflammation and pain). Record review of Resident #1's Order Summary Report dated 4/23/25 reflected an order for Tramadol Hcl (a controlled pain medication) oral tablet 50 mg. Give one tablet by mouth every 8 hours for pain. Record review of Resident #2's Individual Control Drug Record for Tramadol Hcl tab 50 mg dated 2/16/25 reflected the medication was signed out on the following dates: 2/20/25 at 5:00 PM by LVN A (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/22/25 at 7:00 AM by LVN B 2/22/25 at 1:00 PM by LVN B 2/22/25 at 7:00 PM by LVN B 2/23/25 at 7:00 AM by LVN B 2/23/25 at 1:00 PM by LVN B 2/23/25 at 7:00 PM by LVN B 2/24/25 at 9:00 PM by LVN A 2/26/25 at 6:00 PM by LVN A 3/2/25 at 7:00 AM by LVN B 3/2/25 at 1:00 PM by LVN B 3/2/25 at 7:00 PM by LVN B 3/5/25 at 4:22 PM by LVN A 3/8/25 at 7:00 AM by LVN B 3/8/25 at 1:00 PM by LVN B 3/8/25 at 7:00 PM by LVN B 3/9/25 at 7:00 AM by LVN B 3/9/25 at 1:00 PM by LVN B 3/9/25 at 7:00 PM by LVN B Record review of Resident #1's Licensed Nurse MAR for February 2025 reflected an entry for Tramadol Hcl 50 mg Tab give 1 tablet every 6 hours as needed for pain. No doses were signed as administered by LVN A or LVN B on 2/20/25; 2/22/25; 2/23/25; 2/24/25; 2/25/25; 3/2/25; 3/5/25; or 3/9/25. One dose was signed as administered by LVN B on 3/8/25 at 9:51 AM. Record review of Resident #1's EMR reflected the following entries: 3/8/25 at 9:51 AM: Medication Administration Note: Tramadol Hcl 50 MG give one tablet by mouth every 6 hours as needed for pain. Signed by LVN B. 3/8/25 at 1:00 PM: .No s/sx of pain or discomfort ate [sic] this time. Signed by LVN B. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/8/25 at 2:47 PM: Medication Administration Note: Tramadol Hcl 50 MG give one tablet by mouth every 6 hours as needed for pain. PRN Medication was: Effective. No other nursing notes were found related to the medications signed out on Resident #1's Individual Control Drug Record. Observation and interview on 4/22/25 at 4:15 AM revealed Resident #1 was awake and sitting up in bed. She was confused and disoriented to place and time. She denied complaints of pain other than occasional pain when repositioning. Resident #1 was unable to answer questions related to her medications. 2) Record review of Resident #2's Admission Record dated 4/23/25 reflected a [AGE] year-old male admitted to the facility on [DATE]. Record review of Resident #2's Quarterly MDS assessment dated [DATE] reflected a BIMS score of 15 indicating his cognition was intact. His diagnoses included history of a stroke with left-side hemiparesis (weakness or paralysis on one side of the body); colon cancer; muscle weakness and high blood pressure. Record review of Resident #2's Order Summary Report dated 4/23/25 reflected an order for Tylenol with Codeine #3 (a controlled pain medication) 300-30 mg one tablet by mouth every 8 hours as needed for pain. Record review of Resident #2's Individual Control Drug Record for APAP/Codeine [Tylenol with codeine] tab 300-30mg initiated 2/15/25 reflected the medication was signed out on the following dates: 2/22/25 at 8:00 AM by LVN B 2/22/25 at 8:00 PM by LVN B 2/23/25 at 8:00 AM by LVN B 2/23/25 at 8:00 PM by LVN B 3/2/25 at 8:00 PM by LVN B 3/8/25 at 8:00 PM by LVN B 3/9/25 at 8:00 PM by LVN B Record review of Resident #2's Licensed Nurse MAR for February 2025 reflected no Tylenol with Codeine was signed as administered on 2/22/25 or 2/23/25. Record review of Resident #2's Licensed Nurse MAR for March 2025 reflected no Tylenol with Codeine was signed as administered on any date in March 2025. Record review of Resident #2's EMR reflected there were no entries located within his nursing progress notes related to the administration of Tylenol with codeine between 2/22/25 and 3/9/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 2/22/24 at 7:11 AM, Resident #2 was observed sitting up in bed eating breakfast. He stated he took pain medication on occasion and never had any difficulty getting his medication when needed. He was unable to recall the last time he needed pain medications and stated he had some good days and some bad days. 3) Record review of Resident #3's Admission Record dated 4/23/25 reflected a [AGE] year-old female admitted to the facility 10/5/24. Record review or Resident #3's Annual MDS assessment dated [DATE] reflected she had a BIMS score of 14 indicating she was cognitively intact. Record review of Resident #3's Order Summary Report dated 4/23/25 reflected an order for Tylenol with codeine #3 300-30 mg give 1 tablet by mouth every 6 hours as needed for pain. Record review of Resident #3's Individual Control Drug Record for APAP/Codeine [Tylenol with codeine] tab 300-30mg dated 2/1/25 reflected the medication was signed out as administered on the following dates: 2/11/25 at 12:00 PM by LVN A 2/15/25 at 8:00 AM by LVN B 2/15/25 at 7:00 PM by LVN B 2/16/25 at 8:00 AM by LVN B 2/16/25 at 2:00 PM by LVN B 2/16/25 at 8:00 PM by LVN B 2/22/25 at 7:00 AM by LVN B 2/22/25 at 5:00 PM by LVN B 2/23/25 at 7:00 AM by LVN B 2/25/25 at 7:00 PM by LVN A 3/2/25 at 7:00 AM by LVN B 3/2/25 at 5:00 PM by LVN B 3/6/25 at 8:48 PM by LVN A 3/8/25 at 7:00 AM by LVN B 3/8/25 at 5:00 PM by LVN B (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #3's Licensed Nurse MAR for February 2025 reflected an entry for Tylenol with Codeine #3 tablet 300-30 mg give 1 tablet every 6 hours as needed for pain. No doses were signed as administered on 2/11/25; 2/16/25; 2/23/25; or 2/25/25. One dose was signed as administered on 2/15/25 at 9:32 PM by LVN B and one dose was signed as administered on 2/22/25 at 10:29 AM by LVN B. Record review of Resident #3's Licensed Nurse MAR for March 2025 reflected an entry for Tylenol with Codeine #3 tablet 300-30 mg give 1 tablet every 6 hours as needed for pain. No doses were signed as administered on 3/2/25 or 3/6/25. One dose was signed as administered on 3/8/22 at 10:05 AM by LVN B. Record review of Resident #3's EMR reflected there were no entries located within his nursing progress notes related to the administration of Tylenol with codeine on 2/11/25; 2/16/25; 2/23/25; 2/25/25; 3/2/25; or 3/6/25. One nursing Medication Administration Note was entered on 3/8/22 at 10:05 AM by LVN B reflecting she received 1 tablet of Tylenol with Codeine #3 300-30 mg. During an interview on 4/22/25 at 7:15 AM, Resident #3 denied any concerns related to her pain management. 4) Record review of Resident #4's Admission Record dated 4/23/25 reflected a [AGE] year-old female initially admitted to the facility on [DATE]. Record review of Resident #4's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score on 14 indicating she was cognitively intact. Her diagnoses included coronary artery disease (narrowing of the arteries in the heart); hypertension; peripheral vascular disease (narrowing of the blood vessels outside the heart and brain affecting blood flow); stroke, hemiplegia (weakness or paralysis on one side of the body often the result of a stroke); and pain. Record review of Resident #4's Order Summary Report dated 4/23/25 reflected an order for hydrocodone/APAP 7.5/325 mg 1 tablet every 6 hours as needed for pain. Record review of Resident #4's Individual Control Drug Record for hydrocodone/APAP 7.5/325 mg dated 2/11/25 reflected the medication was signed out as administered on the following dates: 2/12/25 at 3:00 PM by LVN A 2/13/25 at 4:00 AM by LVN C 2/13/25 at 9:14 PM by LVN A 2/14/25 at 10:00 AM by LVN A 2/14/25 at 4:00 PM by LVN A 2/15/25 at 7:00 AM by LVN B 2/15/25 at 1:00 PM by LVN B 2/15/25 at 7:00 PM by LVN B (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/16/25 at 6:00 AM by LVN B 2/16/25 at 12:00 PM by LVN B 2/16/25 at 6:00 PM by LVN B 2/18/25 at 5:12 PM by LVN A 2/19/25 at 3:18 PM by LVN A 2/19/25 at 11:30 PM by LVN C 2/20/25 at 3:50 PM by LVN A 2/22/25 at 1:00 PM by LVN B 2/22/25 at 7:00 PM by LVN B 2/23/25 at 7:00 AM by LVN B 2/23/25 at 1:00 PM by LVN B 2/23/25 at 7:00 PM by LVN B 2/25/25 at 9:35 PM by LVN A 2/27/25 at 5:00 PM by LVN A 2/27/25 at 11:20 PM by LVN C 2/28/25 at 5:48 PM by LVN C 3/2/25 at 7:00 AM by LVN B 3/2/25 at 1:00 PM by LVN B 3/2/25 at 7:00 PM by LVN B 3/3/25 at 4:00 PM by LVN A 3/5/25 at 8:45 PM by LVN A 3/6/25 at 5:33 PM by LVN A 3/8/25 at 8:00 AM by LVN B 3/8/25 at 2:00 PM by LVN B (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/8/25 at 8:00 PM by LVN B 3/9/25 at 7:00 AM by LVN B 3/9/25 at 1:00 PM by LVN B 3/9/25 at 7:00 PM by LVN B Record review of Resident #4's Licensed Nurse MAR for February 2025 reflected an entry for Norco oral tablet 7.5-325 mg (hydrocodone/acetaminophen) 1 tablet every 6 hours as needed for pain. No doses were signed as administered on 2/13/25; 2/14/25; 2/15/25; 2/16/25; 2/18/25; 2/19/25; 2/20/25; 2/23/25; 2/27/25; or 2/28/25. One dose was signed as administered on 2/22/25 at 7:00 AM by LVN B; on 2/25/25 at 3:37 PM by LVN A. Record review of Resident #4's Licensed Nurse MAR for March 2025 reflected an entry for Norco oral tablet 7.5-325 mg (hydrocodone/acetaminophen) 1 tablet every 6 hours as needed for pain. No doses were signed as administered on 3/2/25; 3/3/25; 3/6/25; and 3/6/25. One dose was signed as administered on 3/8/25 at 9:47 AM by LVN B; and on 3/6/25 at 10:21 AM. Record review of Resident #4's EMR reflected there were no entries located within his nursing progress notes related to the administration of hydrocodone on 2/13/25; 2/14/25; 2/15/25; 2/16/25; 2/18/25; 2/19/25; 2/20/25; 2/23/25; 2/27/25; 2/28/25; 3/2/25; 3/3/25; 3/6/25; and 3/6/25. During an interview on 4/23/25 at 1:54 PM, Resident #4 stated she always received her pain medications when requested. She stated she suffered from frequent leg pain related to her vascular disease and poor circulation and was scheduled for surgery soon. 5) Record review of Resident #5's Admission Record dated 4/23/25 reflected a [AGE] year-old female initially admitted to the facility on [DATE]. Record review of Resident #5's Quarterly MDS assessment dated [DATE] reflected she had a BIMS score of 9 indicating moderately impaired cognition. Her diagnoses included, heart failure (condition where the heart does not pump properly); hypertension; stroke, kidney failure, non-Alzheimer's dementia and chronic pain. Record review of Resident #5's Order Summary Report dated 4/23/25 reflected an order for Tylenol with codeine #3 300-30 mg give 1 tablet by mouth every 6 hours as needed for pain. Record review of Resident #5's Individual Control Drug Record for APAP/Codeine [Tylenol with codeine] tab 300-30mg dated 1/14/25 reflected the medication was signed out as administered on the following dates: 2/9/25 at 6:00 PM by LVN B 2/15/25 at 8:00 AM by LVN B 2/15/25 at 7:00 PM by LVN B (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675112	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Coral Rehabilitation and Nursing of Arlington	1112 Gibbins Rd Arlington, TX 76011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/16/25 at 8:00 AM by LVN B 2/16/25 at 7:00 PM by LVN B 2/22/25 at 8:00 AM by LVN B 2/22/25 at 7:00 PM by LVN B 2/23/25 at 8:00 AM by LVN B 2/23/25 at 7:00 PM by LVN B 3/2/25 at 7:00 PM by LVN B 3/8/25 at 7:00 AM by LVN B 3/8/25 at 7:00 PM by LVN B 3/11/25 at 8:30 PM by LVN A Record review of Resident #5's Licensed Nurse MAR for February 2025 reflected an entry for Tylenol with Codeine #3 tablet 300-30 mg give 1 tablet every 6 hours as needed for pain. No doses were signed as administered on 2/9/25; 2/15/25; 2/16/25; or 2/23/25. One dose was signed as administered on 2/22/25 at 8:36 AM. Record review of Resident #5's Licensed Nurse MAR for March 2025 reflected an entry for Tylenol with Codeine #3 tablet 300-30 mg give 1 tablet every 6 hours as needed for pain. No doses were signed as administered on 3/2/25; 3/8/25; or 3/11/25. Record review of Resident #5's EMR reflected there were no entries located within his nursing progress notes related to the administration of Tylenol with codeine on 2/9/25; 2/15/25; 2/16/25; 2/23/25; 3/2/25; 3/8/25; or 3/11/25. One nursing Medication Administration Note was entered on 2/22/25 at 8:36 AM by LVN B reflecting she received 1 tablet of Tylenol with Codeine #3 300-30 mg. During an interview on 4/23/25 at 2:26 PM, Resident #5 stated she had chronic pain and believed it was managed well. She denied concerns and stated the staff brought her medications when she requested it. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/22/25 at 5:35 AM, LVN C stated staff were required to count controlled medications anytime they were passing their keys onto another nurse for any reason. They reviewed the control drug record and compared the count on the page to the number of medications in their carts. LVN C stated she had recently noticed some staff had been signing out a lot of medications for residents. She noticed they were not always signed out on the MAR and there were no nurses' notes written. She stated she reported the issue to her DON because it could sometimes indicate a drug diversion. She stated the DON investigated the issue immediately. She did not recall the name of the staff member but stated they no longer worked there. LVN C stated the DON had conducted in-service training for all the nurses and discussed the importance of documenting medication administration especially pain meds. She stated she realized she had missed a few MAR entries herself and believed she may have become distracted at the time of the administrations. LVN C stated documenting medications on the MARs and progress notes was important for assessing pain and communicating with other nurses and physicians about the residents' needs. She stated she had not received any complaints from residents related to their pain management. During an interview on 4/22/25 at 5:48 AM, LVN D stated she had not had any complaints or concerns from her residents related to pain management. She stated they had recently received in-service training from the DON related to the importance of documenting all medications administered in the MAR and nurses' notes and to report any unusual situations with their controlled medications. LVN D stated proper documentation was important because other nurses and physicians review the MARs and notes and it could help identify a change in a resident's condition. In an interview on 4/22/25 at 7:21 AM, the DON stated LVN C had approached her about her concerns related to the control records and LVN B, and she immediately started an investigation. She stated she became concerned about a possible drug diversion because the same nurse was pulling controlled medications for all her residents on her shifts. She stated she reported it to the Administrator and the State. She stated LVN B was immediately suspended and no longer worked for the facility. The DON stated she had conducted in-service training for all nursing staff and would provide her documentation. During an interview on 4/22/25 at 8:14 AM, the Administrator stated he and the DON had conducted the investigation and in-service training related to a possible drug diversion. He stated LVN D had denied any wrongdoing and no longer worked for the facility. He stated he believed the risk to residents was theft of medications and residents not having the medications they needed. He did not believe any residents had missed any doses of medications and could not confirm any theft. Record review of a written statement dated 3/14/25 and provided by LVN B reflected, [LVN B Statement] I did my pain assessments Q shift, if they are above a 4 [on a 1-10 scale for pain-10 being most severe] I give pain medicine. I have done this my whole career and there has never been an issue. I feel if the pain is not controlled, the resident will act out. Signed by LVN B. Attempts to reach LVN B on 4/23/25 at 11:25 AM and 11:35 AM via telephone were unsuccessful. A message was left via voice mail and no call was received prior to exiting the facility. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record on 4/23/25 at 1:00 PM, the DON reviewed the sampled residents Control Drug Records, MARs, and nurses notes. She stated there were two main staff, LVN B and LVN A. LVN B had been terminated and LVN A just quit this week by failing to show up to work or call in. She stated LVN A had not responded to her phone calls. The DON stated, immediately after the allegation, she did a facility wide audit of all the controlled medications ensuring medication counts and reviewing the nurse's documentation. She stated she had notified the pharmacy consultant as well who assisted with the review. The DON stated all controlled medication counts were correct and all medications were accounted for. She stated she found multiple instances where LVN A and LVN B had failed to properly document the PRN medications in the resident's MAR and progress notes. She stated she found a few instances with other nurses, but they were rare. The DON stated she checked on every resident cared for by LVN A and LVN B and none of them had any complaints related to unrelieved pain or lack of medications. She initiated in-service training for all nurses and medication aides. The DON stated the in-service training included the facility's pharmacy policy, and the importance of proper documentation of medication administration. She stated the risk for failing to document on the MAR and progress notes included a medication error if a nurse was unaware a resident had already received pain medication. She stated the physicians and pharmacy consultants reviewed the MARs as well and may be unaware of a resident's needs. The DON stated the nurses were responsible for ensuring their documentation was complete and policies were followed. She stated she and the pharmacy consultant regularly monitored controlled medications during their monthly reviews. Attempts to reach LVN A on 4/23/25 at 1:36 PM and 1:45 PM were unsuccessful. Message was left via voicemail and no call was received prior to exiting the facility. During an observation, interview, and record review on 4/23/25 at 2:10 PM, LVN F and RN E were observed counting controlled medications on the 400 Hall nurse's medication cart. No medication discrepancies were observed during the count. LVN F stated she had recently received in-service training related to pharmacy services. She stated she had not received any complaints from resident related to their medication regimen. LVN F stated it was very important to document any medications administered immediately after a resident takes the medication. She stated the risk was failing to document an assessment and not having a record available for other nurses and the physicians. During an observation, interview and record review on 4/23/25 at 3:04 PM, RN G reviewed and counted the controlled medications within her 300 Hall nursing medication cart. She stated she had received in-service training recently related to pharmacy services and the importance of documenting all PRN medications on the MAR and in the nurses' notes. She stated she documented in the MAR immediately after giving any medications. She stated the risk included other nurses following her may be unaware of medications received by the resident and physicians reviewed their documents as well. She stated there was a risk for medication errors and drug diversions. Record review of in-service documents dated 3/13/25 reflected topics included: All PRN medications must be signed out on the MAR and on the narcotic count sheet. All medications must be counted at the beginning and end of every shift; The MAR and Narcotic count sheet should match; the 5 rights to medications administration; and medication destruction procedures; and the pharmacy services policy. The attached signature sheets included the names and signatures of all facility nurses and medication aides. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the facility's policy and procedure titled, Administering Medications, dated Revised December 2009 reflected: Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation: .2. The Director of Nursing Services will supervise and direct all nursing personnel who administer medications and/or have related functions. 3. Medications must be administered in accordance with the orders, including any required time frame .12. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. Record review of the facility's policy and procedure titled, Pharmacy Services Overview, dated Revised April 2007 reflected the following: Policy Statement: The facility shall accurately and safely provide or obtain pharmacy services, including the provision of routine and emergency medications and biologicals, and the services of a licensed Pharmacist. Policy Interpretation and Implementation: .3. The facility shall contract with a licensed Pharmacist to help it obtain and maintain timely and appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet state and federal requirements. This includes, but is not limited to, collaborating with the facility and Medical Director to: Develop, implement, evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmacy services (including ordering, delivery and acceptance, storage, distribution, preparation, dispensing, administration, disposal, documentation, and reconciliation of all medications and biologicals in the facility; .f. help the facility assure that medications are requested, received, and administered in a timely manner as ordered by authorized prescribers; g. Give the facility's Director of Nursing Services, Medical Director, and staff feedback about performance and practices related to medication administration and medication errors; .