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| TERRABELLA ASHEBORO | 2925 ZOO PARKWAY ASHEBORO, NC 27204 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on March 10, 2022 and March 11, 2022. | D 000 | | |
| D 372 | 10A NCAC 13F .1004 (o) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br><br>(o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure medications were borrowed only in an emergency and replaced promptly for 2 of 5 sampled residents (#4 and #6) with orders for anti-anxiety medication.<br><br>The findings are:<br><br>1. Review of Resident #4's current FL2 dated 10/25/21 revealed:<br>-Diagnoses included Alzheimer's disease and anxiety with depression.<br>-There was an order for lorazepam (a Schedule IV controlled substance used to treat symptoms of anxiety) 1mg twice daily.<br><br>Review of Resident #4's January 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for lorazepam 1mg take 1 tablet daily scheduled at 8:00am and 8:00pm. | D 372 | | |

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| D 372 | Continued From page 1<br>-There was documentation that lorazepam 1mg had been administered daily at 8:00am and 8:00pm from 01/01/22 through 01/31/22 except for the 8:00pm dose on 01/23/22 where it was documented that Resident #4 was out of the facility.<br><br>Review of Resident #4's controlled substance count sheet (CSCS) received from the pharmacy on 12/27/21 for 60 lorazepam 1mg tablets compared to Resident #4's January 2022 eMAR revealed lorazepam 1mg was signed out twice daily from 01/01/22 through 01/31/22.<br><br>Review of Resident #4's February 2022 eMAR revealed:<br>-There was an entry for lorazepam 1mg take 1 tablet daily scheduled at 8:00am and 8:00pm.<br>-There was documentation that lorazepam 1mg had been administered daily at 8:00am and 8:00pm from 02/01/22 through 02/28/22 except for the 8:00pm doses on 02/04/22 and 02/08/22 where it was documented that resident refused.<br><br>Review of Resident #4's March 2022 eMAR revealed:<br>-There was an entry for lorazepam 1mg, take 1 tablet daily scheduled at 8:00am and 8:00pm.<br>-There was documentation that lorazepam 1mg had been administered daily at 8:00am and 8:00pm from 03/01/22 through 03/10/22, except for the 8:00am dose on 03/06/22 where it was documented that resident was unable to take the medication, the reason was not specified.<br><br>Review of Resident #4's CSCS received from the pharmacy on 01/31/22 for 60 lorazepam 1mg tablets compared to Resident #4's February and March 2022 eMARs revealed:<br>-The last lorazepam 1mg tablet was signed out | D 372 | | |

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on 03/05/22 at 9:15am.
-Lorazepam 1mg was documented as administered on the eMAR but not signed out on the CSCS at 8:00pm on 03/05/22, 03/06/22, and 03/07/22 through 03/10/22, and at 8:00am from 03/07/22 through 03/10/22.

Observation of medication on hand on 03/10/22 at 2:30pm revealed there were no lorazepam 1mg tablets available for administration.

Interview with a medication aide (MA) on 03/10/22 at 2:40pm revealed:
-There was no lorazepam on hand for Resident #4.
-She had told the Resident Care Coordinator (RCC) on 03/07/22 that the lorazepam was running low and needed to be reordered.
-The MAs did not reorder controlled substances, they notified the RCC when controlled substances were running low.
-The RCC was responsible for reordering controlled substances because a new written prescription was needed by the pharmacy for each refill.
-She had documented Resident #4's lorazepam as administered that morning (03/10/22) and the previous morning (03/09/22) because the MAs had been taking lorazepam 1mg tablets from another resident who was ordered lorazepam 1mg to take as needed.
-She had been told by one of the supervisors, she could not remember who, that it was "okay" to borrow lorazepam from another resident with the same dose as long as they wrote on that resident's CSCS that the tablet was being taken and documented with Resident #4's initials.

Review of another resident's CSCS received from the pharmacy on 02/08/22 for 90 lorazepam 1mg

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tablets revealed:
-The order was for lorazepam 1mg take 1 tablet every 4 hours as needed.
-There were 10 tablets documented as signed out on the CSCS.
-There were 8 tablets documented as signed out with Resident #4's initials next to it.
-There were two lorazepam 1mg tablets that were signed out to the other resident on 02/25/22 at 11:00am and 03/04/22 at 10:23.

Review of the facility's medication management policy revealed:
-There were no specific instructions for staff regarding borrowing medication from one resident to give to another resident.
-Staff were responsible for reordering medications as early as the pharmacy would allow, or 5-7 days before the medication supply ran out.

Interview with the RCC on 03/10/22 at 2:50pm revealed:
-She was responsible for requesting refills of controlled substances from the primary care provider (PCP).
-The MAs were supposed to let her know that a refill was needed prior to Resident #4's lorazepam running out.
-The PCP was at the facility every Thursday so that was when she would request refills for prescriptions from the PCP that would be needed by the following week.
-She was aware that Resident #4 had ran out of lorazepam, but only because she had worked as a MA the evening prior and noticed there was no lorazepam to administer to Resident #4 at 8:00pm when she was due.
-The MAs had told her that Resident #4's lorazepam was getting low, but not that she would

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be out of the medication prior to the PCP coming to the facility on Thursday 03/10/22 when she could request the refill.
-The MAs had not notified her that Resident #4 was out of lorazepam or she would have called the PCP to send the prescription electronically to the pharmacy.
-The PCP had been to the facility earlier that day (03/10/22) and she had requested the lorazepam refill for Resident #4 during that visit.
-She expected the lorazepam to be delivered by the pharmacy that evening.
-The MAs had been told not to borrow medication from one resident to give to another resident.

Telephone interview with a representative from the facility's contracted pharmacy on 03/10/22 at 3:30pm revealed:
-They had not yet received a refill request for Resident #4's lorazepam.
-They had dispensed lorazepam for Resident #4 on 12/27/21 and 01/31/22 with a quantity of 60 tablets which would be a 30-day supply.

Interview with the Special Care Unit (SCU) MA/Supervisor on 03/03/22 at 4:00pm revealed:
-She was aware that Resident #4 had been out of her lorazepam.
-She was aware that the MAs were using lorazepam which belonged to another resident for Resident #4.
-The MAs had told her on 03/07/22 that Resident #4 was out of lorazepam, but she did not request a refill of the medication because she was told it had already been reordered.
-She did not tell the MAs that it was "okay" to borrow lorazepam from another resident to give to Resident #4 until her refill arrived and she did not know who had told the MAs that.
-She was under the impression that it was "okay"

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for staff to borrow medication from one resident to give to another as long as they documented it so that it could get "paid back" to them.
-She did not know what the process was to pay back the lorazepam to the resident it was borrowed from.

Interview with the Administrator on 03/10/22 at 4:15pm revealed:
-She was not aware that Resident #4 had run out of lorazepam.
-She was not aware that MAs were borrowing lorazepam from another resident to give to Resident #4 until her refill arrived.
-The MAs were aware they were not allowed to take medication from one resident to give to another resident.
-She and the supervisors completed medication cart audits, and one aspect of the audit was to verify the facility had all ordered medications on hand.
-The last medication cart audit was a week or two ago.
-The MAs counted controlled substances together at every shift change.
-The MAs were supposed to notify either herself or the RCC when a controlled substance needed a new refill ordered by the PCP prior to that medication running out.
-If a MA saw that lorazepam was due for administration but was not available on the medication cart, they should tell her or the RCC so that they could request a refill right away.
-They should not assume it had been reordered and borrow the medication from another resident.

Interview with a MA on 03/11/22 at 9:30am revealed:
-If a controlled substance ran out and there were no available refills on that order, the MA was

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responsible for notifying the RCC who would then contact the PCP for a new refill order.
-The MAs should be requesting a refill when the pill count was down to 8 or reached the blue shaded "reorder" column on the medication card.
-She had not borrowed lorazepam from another resident for Resident #4.
-It was against facility policy to borrow medication from one resident to give to another resident unless there was an emergency.

Telephone interview with a second MA on 03/11/22 at 10:30am revealed:
-She had worked day shift on 03/07/22 and 03/08/22 and had documented the first and third borrowed lorazepam tablets from another resident's CSCS to give to Resident #4.
-She did not know when Resident #4 had run out of her lorazepam.
-She was told that MAs were allowed to borrow lorazepam from another resident for Resident #3 as long as they signed the lorazepam out on the other resident's CSCS and put Resident #4's initials next to it, but she could not remember who had told her that.
-She had not requested a refill of Resident #4's lorazepam because she was told that it had already been reordered by the MA who worked the shift prior to hers.
-MAs were supposed to request a medication refill from the RCC when the pill count reached the blue shaded "reorder" column in the medication card or when they used the last pill in the medication card.

Telephone interview with a third MA on 03/11/22 at 10:40am revealed:
-She had worked evening shift on 03/07/22 and 03/08/22 and had documented the second and fourth borrowed lorazepam tablets from another

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resident's CSCS to give to Resident #4.
-She had been told by the MA who worked the shift prior to hers that she could borrow lorazepam if she signed out the lorazepam on the other resident's CSCS and put Resident #4's initials next to it.
-She did not know who had told the other MA that it was okay to borrow lorazepam from another resident.
-She did not request a refill of lorazepam from the RCC because she was told that it had already been reordered.
-MAs were supposed to request lorazepam refills from the RCC prior to the medication running out.
-She did not know how the other resident would be repaid for the lorazepam that was taken from her medication card.

Telephone interview with a fourth MA on 03/11/22 at 3:00pm revealed:
-She had worked on 03/05/22 and had documented the last tablet of lorazepam used for Resident #4.
-She had let the RCC know that Resident #4 was out of lorazepam and needed it refilled.
-Refill requests were supposed to be sent to the PCP once a medication reached 10 tablets remaining.
-She documented on Resident #4's eMAR that she had administered lorazepam at 8:00pm on 03/05/22 and 03/06/22 but she could not remember if she administered it or not.
-She did not document borrowing any tablets of lorazepam from another resident.
-MAs were allowed to borrow lorazepam as long as the resident they were borrowing from had the same dose, and the lorazepam was ordered to take as needed; as long as they put Resident #4's initials next to where they were signing out the tablet on the other resident's CSCS.

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Telephone interview with Resident #4's PCP on 03/11/22 at 2:40pm revealed:
-She was not aware that Resident #4 had run out of lorazepam.
-She had not received a refill request for Resident #4's lorazepam prior to 03/10/22 when she was at the facility and the RCC had requested the refill.
-Facility staff should be letting her know about all medications that need to be refilled by the following week when she was at the facility on Thursdays.
-She was not aware that the MAs had been borrowing lorazepam from another resident to give to Resident #4.
-If an MA did not have lorazepam available to administer to Resident #4, instead of borrowing from another resident they should have called her to send the refill to the pharmacy electronically.
-She expected MAs to administer medications as ordered to the resident that it was ordered for, or to notify her if they were unable to administer medications as ordered.

2. Review of Resident #6's current FL2 dated 12/21/21 revealed diagnoses included encephalopathy and hypotension.

Resident #6's physician's order dated 02/10/22 revealed:
-There was an order for lorazepam 0.5mg take 1 tablet two times a day and an order for lorazepam 0.5mg every 8 hours as needed for anxiety.
-Both lorazepam orders had an original order date of 10/28/21.

Review of Resident #6's January 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg take 1

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tablet two times a day with a scheduled administration time of 9:00am and 8:00pm.
-There was documentation Lorazepam 0.5mg 1 tablet two times a day was administered 50 of 61 opportunities from 01/01/22 - 01/31/22.
-There was an entry for lorazepam 0.5mg take 1 tablet every 8 hours as needed for anxiety.
-There was no documentation lorazepam 0.5mg take 1 tablet every 8 hours as needed was administered from 01/22-01/31/22.

Review of Resident #6's controlled substance count sheet (CSCS) for January 2022 revealed:
-There was a CSCS from the contracted pharmacy dated 10/29/21 for lorazepam 0.5mg take 1 tablet every 8 hours as needed for 60 of 120 tablets.
-There were 6 tablets signed out from 01/01/22-01/03/22.

Review of Resident #6's February 2022 eMAR revealed:
-There was an entry for lorazepam 0.5mg, take 1 tablet two times a day scheduled at 9:00am and 8:00pm.
-There was documentation that lorazepam 0.5mg had been administered 51 of 56 opportunities from 02/01/22 through 02/28/22.
-There was an entry for lorazepam 0.5mg take 1 tablet every 8 hours as needed for anxiety.
-There was no documentation lorazepam 0.5mg take 1 tablet every 8 hours was administered 0101/22-01/31/22

Review of Resident #6's controlled substance count sheet (CSCS) for February 2022 revealed:
-There was a CSCS from the contracted pharmacy dated 02/10/22 for lorazepam 0.5mg take 1 tablet every 8 hours as needed for 60 tablets.

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| D 372 | Continued From page 10<br>-There were 33 tablets documented as signed out from 02/11/22-02/28/22.<br><br>Observation of medication on hand for Resident #6 on 03/11/22 at 10:25am revealed there were 12 lorazepam 0.5mg tablets available for administration that was dispensed 02/10/22 for 60 tablets.<br><br>Interview with a medication aide (MA) on 03/11/22 at 10:30am revealed:<br>-She used another resident's lorazepam for Resident #6 when she started working at the facility in February 2022.<br>-She had told the Resident Care Coordinator (RCC) on 03/07/22 that the lorazepam was running low and needed to be reordered.<br>-The MAs did not reorder controlled substances, they notified the RCC when controlled substances were running low.<br>-The RCC was responsible for reordering controlled substances because a new written prescription was needed by the pharmacy for each refill.<br>-She had documented Resident #6's lorazepam as administered because the MAs had been taking lorazepam 0.5mg tablets from another resident who was ordered lorazepam 0.5mg to take as needed.<br>-She had been told by one of the supervisors that she could borrow lorazepam from another resident with the same dose and write on the CSCS that the tablet was being taken and document Resident #6's initials by it.<br><br>Review of another resident's controlled substance count sheet (CSCS) January 2022 and February 2022 revealed:<br>-There was a CSCS from the facility's contracted pharmacy dated for 11/10/21 lorazepam 0.5mg | D 372 | | |

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tablets take 1 tablet every 6 hours as needed signed out for 45 of 90 tablets.
-There were 25 tablets documented as signed out to Resident #6 from 01/11/22-01/31/22 by writing her initials beside the signature of the staff dispensing the medication
-There were 4 tablets documented as signed out to Resident #6 from 02/01/22-02/03/22 by writing her initials beside the signature of the staff signing out the medication.

Review of the facility's medication management policy revealed:
-There were no specific instructions for staff regarding borrowing medication from one resident to give to another resident.
-Staff were responsible for reordering medications as early as the pharmacy would allow, or 5-7 days before the medication supply ran out.

Interview with another MA on 03/11/22 at 2:15pm revealed:
-She worked as an MA administering medications in January 2022 and February 2022.
-She was aware that Resident #6 had been out of her lorazepam.
-She had borrowed lorazepam for Resident #6 from another resident's as needed lorazepam writing the resident's initials on the CSCS next to the tablet borrowed.
-The MAs were responsible for notifying the RCC when controlled substances ran out and she would then contact the PCP for a new refill order.
-The MAs should be requesting a refill when the pill count was down to 8 or reached the blue shaded "reorder" column on the medication card.
-The RCC told her in January 2022 to borrow from another resident for Resident #6's lorazepam.

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| TERRABELLA ASHEBORO | 2925 ZOO PARKWAY ASHEBORO, NC 27204 |

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-She could not explain how the lorazepam would be "paid back" to the other resident.

Interview with the RCC on 03/11/22 at 2:30pm revealed:
-She was responsible for requesting refills of controlled substances from the primary care provider (PCP).
-The MAs were supposed to let her know at least a week ahead of a controlled prescription running out.
-She did not remember any MA telling her that Resident #6 needed a new order for her lorazepam.
-She would have requested a narcotic written prescription to be sent to the contracted pharmacy from the PCP unless the resident had enough tablets to last until the PCP's Thursday visit.
-Borrowing medications between residents was discouraged unless it was a life or death emergency.

Telephone interview with a representative from the facility's contracted pharmacy on 03/11/22 at 11:55am revealed:
-There was an original order for Resident #6's lorazepam 0.5mg 1 tablet two times a day with 60 tablets dispensed on 10/29/21 and 60 tablets dispensed on 02/10/22.
-There was an original order for Resident #6's lorazepam 0.5mg 1 tablet every 8 hours as needed on 10/28/21 with 30 tabs dispensed on 10/20/21 and 90 tablets dispensed on 11/10/21.

Telephone interview with Resident #4's PCP on 03/11/22 at 2:40pm revealed:
-She thought hospice services might be ordered Resident #6's lorazepam in January 2022.
-She was not aware that Resident #6 had run out

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of lorazepam until early February 2022.
-Facility staff should be letting her know about all medications that need to be refilled by the following week when she was at the facility on Thursdays.
-She was not aware that the MAs had been borrowing lorazepam from another resident to give to Resident #6.
-If an MA did not have lorazepam available to administer to Resident #6, instead of borrowing from another resident they should have called her to send the refill to the pharmacy electronically.
-She expected MAs to administer medications as ordered to the resident that it was ordered for, or to notify her if they were unable to administer medications as ordered.

Telephone interview with the Administrator on 03/10/22 at 4:15pm revealed:
-It was not the facility's policy to share medications unless it was an emergency.
-She was not aware that Resident #6 had run out of lorazepam.
-She was not aware that MAs were borrowing lorazepam from another resident to give to Resident #6 until her refill arrived.
-The MAs were aware they were not allowed to take medication from one resident to give to another resident.
-She and the supervisors completed medication cart audits, and one aspect of the audit was to verify the facility had all ordered medications on hand.
-The last medication cart audit was a week or two ago.
-The MAs counted controlled substances together at every shift change.
-If a MA saw that lorazepam was due for administration but was not available on the medication cart, they should tell her or the RCC

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| D 372 | Continued From page 14<br>so that they could request a refill right away.<br>-She expected the MAs to notify the RCC or herself before narcotic tablets and prescriptions ran out. | D 372 | | |
| D935 | G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency<br><br>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.<br><br>(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:<br>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:<br>a. The key principles of medication administration.<br>b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.<br>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.<br>(3) Within 60 days from the date of hire, the individual must have completed the following:<br>a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:<br>1. The key principles of medication administration. | D935 | | |

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| D935 | Continued From page 15<br>2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.<br>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure 4 of 6 sampled staff who administered medications had passed the written medication aide exam within 60 days of completing the medication clinical skills competency validation checklist (Staff D, C, B); had completed the state-approved 5-hour medication aide training course (Staff E); and had completed the medication clinical skills competency validation checklist (Staff C and B).<br><br>The findings are:<br><br>1. Review of Staff D's, medication aide (MA) personnel record revealed:<br>-Staff D was hired on 06/02/20 as a personal care aide (PCA).<br>-There was a certificate of completion dated 08/05/21 for the 5-hour state approved medication aide training.<br>-There was a certificate of completion dated 08/12/21 for the 10-hour state approved medication aide training.<br>-There was documentation of a medication clinical skills competency validation checklist completed for Staff D dated 09/12/21.<br>-There was no documentation Staff D had successfully passed the written medication aide exam. | D935 | | |

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| D935 | Continued From page 16<br><br>Review of residents' medication administration records for January, February, and March 2022 revealed:<br>-Staff D documented administration of medications for 3 of 31 days in January 2022.<br>-Staff D documented administration of medications for 6 of 28 days in February 2022.<br>-Staff D documented administration of medications for 1 of 9 days from 03/01/22 through 03/09/22.<br><br>Interview with Staff D on 03/11/22 at 4:00pm revealed:<br>-She did not take the written medication aide exam.<br>-She tried to take the online written medication aide exam, but the proctor never showed up.<br>-She was initially unaware that she was required to take the written medication aide exam within 60 days of completing the medication clinical skills checklist.<br>-She was scheduled to take the written medication aide exam on 03/14/22.<br><br>Interview with the Business Office Manager on 03/11/22 at 2:50pm revealed that Staff D began medication aide duties in November 2021.<br><br>Interview with the Resident Care Coordinator (RCC) on 03/11/22 at 3:20pm revealed:<br>-Staff D was scheduled to take the written medication aide exam sometime in November 2021 but was unable to take the exam.<br>-Staff D administered medications to residents in January 2022.<br><br>Telephone interview with the Executive Director (ED) on 03/11/22 at 4:12pm revealed:<br>-Staff D had signed up for the written medication | D935 | | |

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aide exam, but the online proctor did not show up.
-Staff D was scheduled to take the written medication aide exam on 03/14/22.

Refer to interview with the Resident Care Coordinator (RCC) on 03/11/22 at 3:15pm.

Refer to telephone interview with the Executive Director (ED) on 03/11/22 at 4:11pm.

2. Review of Staff E's, medication aide (MA) personnel record revealed:
-Staff E was hired on 02/01/22.
-There was no certificate of completion for the 5-hour state approved medication aide training.
-There was documentation of a medication clinical skills competency validation checklist completed for Staff E dated 02/02/22.
-There was documentation Staff E had successfully passed the written medication aide exam on 06/28/17.

Observation on 03/11/22 between 8:25am and 8:36am revealed that Staff E administered medications to multiple residents.

Review of residents' medication administration records for February and March 2022 revealed:
-Staff E documented administration of medications for 15 of 28 days in February 2022.
-Staff E documented administration of medications for 6 of 9 days from 03/01/22 through 03/09/22.

Interview with Staff E on 03/11/22 at 10:47am revealed:
-She thought that she took the written MA exam in 2017.
-She thought that she had completed the required

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| D935 | Continued From page 18<br>medication aide training.<br><br>Interview with the Resident Care Coordinator (RCC) on 03/11/22 at 3:16pm revealed she thought that Staff E had completed the required 5-hour state approved medication aide training.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 03/11/22 at 3:15pm.<br><br>Refer to telephone interview with the Executive Director (ED) on 03/11/22 at 4:11pm.<br><br>3. Review of Staff C's, medication aide (MA) personnel record revealed:<br>-Staff C was hired on 08/27/21, as a personal care aide (PCA).<br>-There was a certificate of completion dated 01/24/22 for the 5-hour state approved medication aide training.<br>-There was a certificate of completion dated 01/26/22 for the 10-hour state approved medication aide training.<br>-There was no documentation of a completed medication clinical skills competency validation checklist.<br>-There was no documentation Staff C had successfully passed the written medication aide exam.<br><br>Review of residents' medication administration records for February and March 2022 revealed:<br>-Staff C documented administration of medications for 2 of 28 days in February 2022.<br>-Staff C documented administration of medications for 3 of 9 days from 03/01/22 through 03/09/22.<br><br>Telephone interview with Staff C on 03/11/22 at 10:30am revealed: | D935 | | |

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| D935 | Continued From page 19<br>-She started working as a medication aide (MA) about two weeks ago.<br>-She thought that she had completed all her training, including the medication clinical skills competency validation checklist.<br><br>Interview with the Business Office Manager on 03/11/22 at 2:51pm revealed that Staff C began medication aide duties within the last few weeks.<br><br>Interview with the Resident Care Coordinator (RCC) on 03/11/22 at 3:17pm revealed:<br>-She thought that Staff C had completed her medication clinical skills competency validation checklist.<br>-She thought that Staff C had taken the written medication aide exam or was registered to take the exam.<br><br>Telephone interview with the Executive Director (ED) on 03/11/22 at 4:15pm revealed she thought that Staff C had completed all of her training, including the medication clinical skills competency validation checklist.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 03/11/22 at 3:15pm.<br><br>Refer to telephone interview with the Executive Director (ED) on 03/11/22 at 4:11pm.<br><br>4. Review of Staff B's, medication aide (MA) personnel record revealed:<br>-Staff B was hired on 12/17/21 as a personal care aide (PCA).<br>-There was no documentation of a completed medication clinical skills competency validation checklist.<br>-There was no documentation Staff B had successfully passed the written medication aide | D935 | | |

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| D935 | Continued From page 20<br>exam.<br><br>Review of residents' medication administration records for February and March 2022 revealed:<br>-Staff B documented administration of medications for 14 of 28 days in February 2022.<br>-Staff B documented administration of medications for 6 of 9 days from 03/01/22 through 03/09/22.<br><br>Telephone interview with Staff B on 03/11/22 at 10:40am revealed:<br>-She started working as a medication aide (MA) about two weeks ago.<br>-She thought that she had completed all her training, including the medication clinical skills competency validation checklist.<br><br>Interview with the Business Office Manager on 03/11/22 at 2:50pm revealed that Staff B began medication aide duties within the last few weeks.<br><br>Interview with the Resident Care Coordinator (RCC) on 03/11/22 at 3:18pm revealed that Staff B was scheduled to take her written medication aide exam on 03/14/22.<br><br>Telephone interview with the Executive Director (ED) on 03/11/22 at 4:14pm revealed she thought that Staff B had completed all of her training, including the medication clinical skills competency validation checklist.<br><br>Refer to interview with the Resident Care Coordinator (RCC) on 03/11/22 at 3:15pm.<br><br>Refer to telephone interview with the Executive Director (ED) on 03/11/22 at 4:11pm.<br>_____ | D935 | | |

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| D935 | Continued From page 21<br><br>Interview with the RCC on 03/11/22 at 3:15pm revealed:<br>-She helped the medication aides (MAs) to schedule their written exam.<br>-The Resident Services Director (RSD) was typically responsible for ensuring that MAs passed the written medication aide exam within 60 days of completing the medication clinical skills evaluation.<br>-The RSD was typically responsible for ensuring that the 5-hour medication aide training and medication aide skills checklist were completed prior to unsupervised medication administration.<br>-The RSD position was currently vacant and RSD duties were being handled by the Executive Director (ED).<br>-The RCC and ED were responsible for ensuring that MAs passed the written medication aide exam within 60 days of completing the medication clinical skills evaluation.<br><br>Telephone interview with the Executive Director (ED) on 03/11/22 at 4:11pm revealed that the facility's contracted pharmacy consultant typically completed the medication aide clinical skills checklist and required 5-hour training with the MAs. | D935 | | |