STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092032	A. BUILDING: _____ B. WING _____	R 06/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow up survey on June 28 - 29, 2022.	{D 000}		
{D 364}	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or one hour after the prescribed times for 4 of 5 sampled residents (#4, #5, #6, & #7) which included medications for seizures, a blood thinner, pain medications, and mental health medications. The findings are: Review of the facility's census on 06/28/22 revealed there were 24 residents in the assisted living (AL) side and 13 residents in the special care unit (SCU). Review of the facility's staff schedule revealed there was one medication aide (MA) assigned to the AL side and another MA assigned to the SCU. Interview with MA assigned to the AL side on 06/28/22 at 9:30am revealed she had a medication pass at 8:00am and 9:00am. 1. Review of Resident #5's current FL-2 dated 06/16/22 revealed diagnoses included malignant neoplasm of the brain, bipolar disorder, chronic	{D 364}		

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{D 364}	Continued From page 1 kidney disease III, Atrial fibrillation, GERD, osteoarthritis and obesity. Review of Resident #5's physician's orders dated 06/16/22 revealed: -There was an order for Depakote delayed release (used to treat seizures) 500mg three times daily. -There was an order for Eliquis (blood thinner) 5mg two times a day. -There was an order for Zyprexa (used for mental health) 5mg twice daily. Review of Resident #5's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Depakote delayed release 500mg to be administered three times a day at 8:00am, 2:00pm and 8:00pm. -On 06/27/22, the Depakote times were changed to 9:00am, 2:00pm, and 9:00pm. -There was an entry for Eliquis 5mg to be administered two times a day at 9:00am and 8:00pm. -There was an entry for Zyprexa 5mg to be administered two times a day at 9:00am and 8:00pm. Review of Resident #5's Medication Variance Report dated June 2022 revealed: a. The scheduled 9:00am dose of Depakote was administered on 06/16/22 at 11:24, on 06/17/22 at 10:21am, on 06/18/22 at 11:32am, on 06/19/22 at 11:22am, on 06/20/22 at 11:35am, on 06/21/22 at 11:31am, on 06/23/22 at 10:40pm, on 06/25/22 at 11:17am, on 06/26/22 at 12:14pm, on 06/27/22 at 10:45am, on 06/28/22 at 10:48am, and on 06/29/22 at 9:50am. -The scheduled 4:00pm dose of Depakote was administered on 06/15/22 at 6:35pm.	{D 364}		

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{D 364}	Continued From page 2 -Depakote 500mg was administered late 12 of 28 days. Telephone interview with Resident #5's primary care provider (PCP) on 06/29/22 at 1:13pm revealed: -Depakote 500mg was scheduled three times daily to keep an even amount of medication in the bloodstream. -Dosing too close together would affect the levels of medication in the bloodstream and be less effective in controlling seizures. b. The scheduled 9:00am dose of Eliquis was administered on 06/17/22 at 10:20am, on 06/18/22 at 11:33am, on 06/19/22 at 11:22am, on 06/20/22 at 11:35am, on 06/21/22 at 11:31am, on 06/25/22 at 11:16am, on 06/26/22 at 12:13pm, on 06/27/22 at 10:45am, and on 06/28/22 at 10:49am. -The 8:00pm dose of Eliquis had been administered on 06/21/22 at 9:28pm. Telephone interview with Resident #5's primary care provider (PCP) on 06/29/22 at 1:13pm revealed: -Eliquis 5mg was scheduled two times daily to keep an even amount of medication in the bloodstream. -Dosing too close together would affect the levels of medication in the bloodstream and be less effective in clotting of the blood. c.-The 9:00am dose of Zyprexa was administered on on 06/16/22 at 11:25am, on 06/18/22 at 11:35am, on 06/19/22 at 11:29am, on 06/20/22 at 11:31am, on 06/21/22 at 11:32am, on 06/25/22 at 11:18am, on 06/26/22 at 12:19pm, on 06/27/22 at 10:45am, and on 06/28/22 at 10:49am.	{D 364}		

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{D 364}	Continued From page 3 -The 8:00pm dose of Zyprexa had been administered on 06/21/22 at 9:28pm. Telephone interview with Resident #5's primary care provider (PCP) on 06/29/22 at 1:13pm revealed: -Zyprexa 5mg was scheduled two times daily to keep an even amount of medication in the bloodstream. -Dosing too close together would affect the levels of medication in the bloodstream and be less effective in mood stabilization. Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable. _____ Refer to interview with a medication aide on 06/28/22 at 3:00pm. Refer to interview with the Resident Care Coordinator (RCC) on 06/29/22 at 12:45pm. Refer to interview with the Health and Wellness Director (HWD) on 06/29/22 at 8:45am Refer to interview with the Administrator on 06/29/22 at 12:25pm. 2. Review of Resident #4's current FL-2 dated 05/19/22 revealed diagnoses included lumbar radicular pain, peripheral polyneuropathy, coronary artery disease, abdominal aneurysm, right bundle branch block, peripheral artery disease, peripheral vascular disease, renal artery stenosis, hypertension, and general anxiety disorder. Review of Resident #4's physician's orders dated 05/19/22 revealed:	{D 364}		

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{D 364}	Continued From page 4 -There was a medication order for Pregabalin 50mg three times a day (used to treat neuropathic pain). -There was a medication order for Buspar 5mg two times a day (used to treat anxiety). Review of Resident #4's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Pregabalin 50mg to be administered three times a day at 8:00am, 2:00pm and 8:00pm. -There was an entry for Buspar 5mg to be administered two times a day at 8:00am and 5:00pm. Observation on 06/28/22 at 9:20am revealed: -Resident #4 was lying in her bed on her left side. -She was crying and holding a family member's hand who was at her bedside. Interview with Resident #4's family member on 06/28/22 at 9:20am revealed: -The family member stated when she came in that morning (06/28/22) to visit, Resident #4 was in pain and the call light was pulled but no one ever came. -The family member stated she had gone out into the hall after waiting about 15-20 minutes and finally found someone and told them Resident #4 needed her pain medication. -The family was concerned that Resident #4 was not getting her scheduled pain medications on time. -She was scheduled at 8:00am to get medications and she had not received any that morning. Observation on 06/28/22 at 9:22am revealed the MA was in the medication room.	{D 364}		

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{D 364}	Continued From page 5 Observation on 06/28/22 at 9:44am revealed: -The MA entered Resident #4's room holding a medication cup. -The MA told the primary care provider (PCP) who was in Resident #4's room, "I am giving her, her tramadol" (a narcotic medication used to treat moderate to severe pain). -The contents of the medication cup were not observed. -Resident #4's family member was heard to say, "it's your pain medication and your other medications". Review of Resident #4's Medication Variance Report report dated June 2022 revealed: a.-The 8:00am dose of Buspar was administered on 06/02/22 at 9:59am, on 06/03/22 at 9:55am, on 06/04/22 at 11:10am, on 06/05/22 at 10:28am, on 06/07/22 at 12:00pm, on 06/08/22 at 9:54am, on 06/10/22 at 9:37am, on 06/11/22 at 11:00am, on 06/12/22 at 12:08pm, on 06/13/22 at 10:02am, on 06/14/22 at 10:51am, on 06/15/22 at 9:47am, on 06/16/22 at 10:00am, on 06/17/22 at 10:11am, on 06/18/22 at 10:54am, on 06/20/22 at 9:44am, on 06/21/22 at 9:39am, on 06/22/22 at 9:30am, on 06/25/22 at 10:42am, on 06/26/22 at 11:14am, on 06/27/22 at 9:41am, on 06/28/22 at 9:39am, and on 06/29/22 at 9:37am. -Buspar 5mg was administered late 24 of 28 days. -The 8:00pm dose of Buspar was administered on 06/01/22 at 9:04pm. b. -The 8:00am dose of Pregabalin was administered on 06/02/22 at 10:00am, on 06/03/22 at 9:56am, on 06/04/22 at 11:15am, on 06/05/22 at 10:29am, on 06/07/22 at 12:22pm, on 06/11/22 at 11:02am. -On 06/12/22, the 8:00am time was changed to	{D 364}		

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{D 364}	Continued From page 6 9:00am for Pregabalin. -The 9:00am dose of Pregabalin was administered on 06/12/22 at 12:12pm, on 06/13/22 at 10:02am, on 06/14/22 at 10:51am, on 06/17/22 at 2:00pm, on 06/18/22 at 10:54am, on 06/19/22 at 11:00am, on 06/25/22 at 10:44am, and on 06/26/22 at 11:12am. -THE EMAR NOTED THE 9AM AND 2PM DOSES WERE BOTH INITIALED AS BEING ADMINISTERED AT 2 PM ON 06/17/22. -The 2:00pm dose of Pregabalin was administered on 06/03/22 at 3:21pm and on 06/13/22 at 3:03pm. -The 8:00pm dose of Pregabalin was administered on 06/03/22 at 9:05pm and on 06/05/22 at 9:19pm. -Pregabalin 50mg was administered late 18 of 28 days. Telephone interview with Resident #4's primary care provider (PCP) on 06/29/22 at 1:13pm revealed: -Pregabalin was ordered three times a day for pain. -Not receiving Pregabalin as ordered could cause the resident to have neuropathy (weakness, numbness and pain). -The timing of the dosage administration was important to control the neuropathy. -Buspar (used to treat anxiety) was ordered twice a day. -Antianxiety medication could cause drowsiness if given too close to the next dose. Attempted interview with Resident #4 on 06/28/22 at 11:00am was unsuccessful. _____ Refer to interview with a medication aide on 06/28/22 at 3:00pm.	{D 364}		

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{D 364}	Continued From page 7 Refer to interview with the Resident Care Coordinator (RCC) on 06/29/22 at 12:45pm. Refer to interview with the Health and Wellness Director (HWD) on 06/29/22 at 8:45am Refer to interview with the Administrator on 06/29/22 at 12:25pm. Observation of medication pass on 06/28/22 at 11:13am revealed: -The MA prepared medications for Resident #6. -The computer screen shown the medications being prepared in a pink/red color. 3. Review of Resident #6''s current FL-2 dated 11/09/21 revealed diagnoses included type II diabetes mellitus, dementia, chronic gout and hypertension. Review of Resident #6's physician's orders dated 11/09/21 revealed: -There was a medication order for Namenda 10mg (used to treat dementia) twice a day. -There was a medication order for Risperdal 0.25mg (used to treat anxiety) twice a day. -There was a medication order for Tylenol eight hour arthritis pain tablet extended release 650mg (used to treat pain) twice a day. Review of Resident #6's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Namenda 10mg to be administered two times a day at 9:00am and 8:00pm. -There was an entry for Risperdal 0.25mg to be administered two times a day at 9:00am and 8:00pm.	{D 364}		

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{D 364}	Continued From page 8 -There was an entry for Tylenol eight-hour arthritis pain tablet extended release 650mg to be administered two times a day, Review of Resident #6's Medication Time Variance report dated June 2022 revealed: a.-The 9:00am dose of Namenda was administered on 06/01/22 at 11:55am. on 06/02/22 at 10:34am, on 06/03/22 at 11:04am, on 06/04/22 at 10:27am, on 06/05/22 at 10:13am, on 06/07/22 at 11:04am, on 06/08/22 at 10:47am, on 06/10/22 at 10:47am, on 06/18/22 at 11:22am, on 06/19/22 at 11:12am, on 06/20/22 at 11:38am, on 06/21/22 at 11:26am, on 06/22/22 at 11:28am, on 06/26/22 at 12:11pm, on 06/27/22 at 11:02am, and on 06/28/22 at 11:13am. -The 8:00pm dose of Namenda had been administered on 06/01/22 at 9:05pm and on 06/03/22 at 9:06pm. -Namenda 10mg was administered late 18 of 28 days. Telephone interview with Resident #6's primary care provider (PCP) on 06/29/22 at 1:13pm revealed Namenda was ordered two times a day and could cause drowsiness and memory problems if given too close to the next dose. b.-The 9:00am dose of Risperdal was administered on 06/01/22 at 11:55am, on 06/02/22 at 10:35am, on 06/03/22 at 11:03am, on 06/04/22 at 10:27am, on 06/05/22 at 10:13am, on 06/07/22 at 11:04am, on 06/08/22 at 10:56am, on 06/10/22 at 10:47am, on 06/18/22 at 11:23am, on 06/19/22 at 11:12am, on 06/20/22 at 11:38am, on 06/21/22 at 11:28am, on 06/22/22 at 11:27am, and on 06/26/22 at 12:11pm. -The 8:00pm dose of Risperdal was administered on 06/01/22 at 9:05pm and on 06/03/22 at 9:06pm.	{D 364}		

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{D 364}	Continued From page 9 -Risperdal 0.25mg was administered late 16 of 28 days. Telephone interview with Resident #6's primary care provider (PCP) on 06/29/22 at 1:13pm revealed Risperdal was ordered two times a day and could cause sleepiness if given too close to the next dose. c. -The 9:00am dose of Tylenol eight-hour arthritis pain tablet extended release was administered on 06/01/22 at 11:55am, on 06/02/22 at 10:34am, on 06/04/22 at 10:27am, on 06/05/22 at 10:13am, on 06/07/22 at 11:02am, on 06/08/22 at 10:53am, on 06/10/22 at 10:47am, on 06/18/22 at 11:22am, on 06/19/22 at 11:12am, on 06/20/22 at 11:37am, on 06/21/22 at 11:28am, on 06/22/22 at 11:27am, on 06/26/22 at 12:11pm, on 06/27/22 at 10:58am and on 06/28/22 at 11:13am. -The 8:00pm dose of Tylenol eight-hour arthritis pain tablet extended release was administered on 06/01/22 at 9:05pm and on 06/03/22 at 9:06pm. -Tylenol eight-hour arthritis pain tablet extended release 650mg was administered late 17 of 28 days. Telephone interview with Resident #6's primary care provider (PCP) on 06/29/22 at 1:13pm revealed: - Tylenol eight-hour arthritis pain tablet extended release was ordered two times a day for pain. -Not receiving Tylenol eight-hour arthritis pain tablet extended release as ordered could cause the resident to have pain. -The timing of the dosage administration was important to control the pain. Interview with a medication aide on 06/28/22 at 3:00pm revealed:	{D 364}		

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-She worked mainly first shift at the facility.
-She had a meeting that morning and it put her behind getting her medications administered within the one hour before and one hour after times.
-There were 4 medications carts, one each for 100 hall, 200 hall, 300 hall, and 400 hall the special care unit (SCU).
-She administered medications for the assisted living hall only.
-The SCU had a MA for their medications.
-She administered medications for the 100 hall, then 300 hall, then she did the 200 hall last.

Interview with the Resident Care Coordinator (RCC) on 12:45pm revealed:
-She was responsible for the monitoring of the MAs.
-She was not aware that medications were being given late.
-She planned to speak with the Health and Wellness Director (HWD) to have some of the medication's times changed to prevent medication being given late.
-The MAs knew to ask for help with medication administration if they ran late.
-She and the HWD would help to prevent medications from being administered late.

Interview with the Health and Wellness Director (HWD) on 06/29/22 at 8:45am revealed:
-She supervised medication aides (MAs) and the Resident Care Coordinator (RCC).
-She did not know the medications were being given late.
-She had done several trainings at the facility on medication administration, especially to make sure to adhere to the one hour before and one hour after times.
-She expected the MAs to request assistance

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{D 364}	Continued From page 11	{D 364}		

from the RCC (also a MA) and or her (a Registered Nurse-RN) when they were running late with administration of medications.
-She was still learning the role of the HWD.
-She had not been informed by any staff about delayed medication administrations.
-The residents medications showed up on the computer screen in green when the medication time was within the one hour before the scheduled time up to one hour after the scheduled time.
-The medication showed up in yellow when it got close to the end time for it to be given.
-Then it turns red meaning the medication was late at that time.

Interview with the Administrator on 06/29/22 at 12:25pm revealed:
-The MAs were expected to administer medications one hour before up to one hour after the scheduled time.
-The pharmacy enters the orders for medication times to a standard 8:00am for morning medications and 8:00pm for evening or medications to be given at bedtime.
-The facility could call to have those times changed if needed to 9:00am and 9:00pm.
-Medications should be administered as ordered according to how the orders were written by the physician.
-The HWD and the RCC had access to the eMAR system to monitor administration and performed monthly audits.

Based on observations, interviews and record reviews, it was determined Resident #6 was not interviewable.

4. Review of Resident #7's current FL-2 dated 11/09/21 revealed diagnoses included diabetes

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE WAKE FOREST	611 SOUTH BROOKS STREET WAKE FOREST, NC 27587

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{D 364}	Continued From page 12	{D 364}		

mellitus II, hypothyroidism, nausea, glaucoma, hyperlipidemia, hypertension, atherosclerotic heart disease, and vitamin B-12 deficiency anemia.

Review of physician orders for Resident #7 dated 05/17/22 revealed a physican's order for pantoprazole sodium delayed release (generic for Protonix and used to treat stomach disorders such as gastric reflux) 40mg tablet in the morning 30 minutes before breakfast.

Review of the June 2022 EMARs for Resident #7's revealed pantoprazole sodium delayed release 40mg tablet was scheduled to be administered at 8:30am with instructions to be administered before breakfast.

Observations of the medication aide (MA) on 06/29/22 at 10:05am revealed:
-The MA was standing at the medication cart preparing medications for Resident #7 from the resident's electronic medication administration records (EMARs).
-The instructions for the medications on the EMARs were highlighted in red.

Interview with the MA on 06/29/22 at 10:05am revealed:
-She was preparing medications for administration to Resident #7.
-The instructions for the medications were highlighted in red because the medications were due at 8:00am.

Observations of the MA on 06/29/22 at 10:07am revealed:
-The MA approached and entered Resident #7's room.
-The resident was seated on the side of the bed

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with his feet resting on the floor.
-She carried in her hand two medication souffle cups that contained medication tablets.
-Upon request, the MA handed the two soufle cups of medication to the surveyor. There were 8 tablets in one cup and 1 tablet in the second cup.
-The MA handed the soufle cup that contained the 8 tablets to Resident #7 and the resident poured the cup of medications in his mouth at 10:07am.
-The MA then handed the soufle cup that contained the one tablet to Resident #7 and instructed the resident that the tablet was to be placed under his tongue. Resident #7 poured the one tablet in his mouth under his tongue.

Interview with the MA on 06/29/22 at 12:15pm revealed:
-She administered two 8:00am medications to Resident #7 at "about" 10:07am.
-The remainder of the medications were scheduled for 9:00am.
-She forgot to administer Resident #7's 8:00am Protonix this morning after she had administered medications on the 100 hall and 300 hall residents.
-She tried to administer medications to residents who went to the dining room for breakfast first.
-She had been instructed by a supervisor that she could not administer medications in the dining room unless the medication was supposed to be administered with food, so she administered medication first to residents who ate their breakfast in the dining room.
-Resident #7 was supposed to be administered Protonix before meals.
-She administered Resident #7 the Protonix (used to treat stomach disorders) today (06/29/22) at 10:05am.
-Resident #7 did not eat breakfast this morning

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{D 364}	Continued From page 14 (06/29/22). -She was not aware of the resident having complaints of any burping or indigestion. Interview with Resident #7 on 06/29/22 at 12:50pm revealed: -Sometimes he was administered medications as early as 9:00am and sometimes as late as before lunch. -He did not know the names of his medications. -He did not eat breakfast. -He felt nauseous last Wednesday, did not vomit but did not feel like eating. Interview with the Administrator on 06/29/22 at 1:05pm revealed: -She expected medications to be administered when the medications were scheduled to be administered. -If the MA needed assistance, there could be help provided. -She expected there to be documentation explaining why a medication was administered late. Telephone interview with Resident #7's Primary Care Provider (PCP) on 06/29/22 at 1:20pm revealed: -Protonix should be taken on an empty stomach but did not necessarily have to be administered before breakfast. -Since Resident #7 did not eat breakfast, the Protonix being administered at 10:00am would not be a concern.	{D 364}		
{D935}	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home	{D935}		

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{D935}	Continued From page 15 Medication Aides; Training and Competency Evaluation Requirements. (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: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. 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. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 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. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.	{D935}		

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{D935}	Continued From page 16 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 6 sampled staff (Staff B), who was administering medications, had taken and passed the medication aide test within 60 days of completing the medication clinical skills evaluation. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired on 02/01/22 as a medication aide (MA). -There was a job description for a medication aide in the personnel record. -There was documentation of a medication clinical skills validation checklist completed for Staff B on 02/14/22. -There was no documentation Staff B had passed the state approved medication aide test. Interview with Staff B on 06/28/22 at 3:45pm revealed: -She was the MA on duty in the memory care unit. -She had already administered 4:00pm medications and the next medications would be administered at 6:00pm and at 8:00pm. Interview with the Business Office Coordinator (BOC) on 06/20/22 at 11:00am revealed: -She was responsible for ensuring staff trainings and staff qualifications were in the staff personnel records. -Staff B was qualified to work as a medication aide in a nursing home. -She did not know there was a different medication aide examination required to work as a MA in an assisted living facility. -She was in the process of sending Staff B the	{D935}		

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{D935}	Continued From page 17 information needed to register to take the state approved medication aide test for adult care homes. Telephone interview with Staff B on 06/29/22 at 11:20am revealed: -She took a medication aide test at a local community college. -She was "licensed for medication aide on the registry". -She had been employed as a medication aide at the facility since February 2022. -She had been administering medications at the facility since February 2022. -She did not know she needed to take the state approved medication aide examination for adult care homes. Review of a facility resident's electronic medication administration records (eMARs), who resided in the memory care unit, for May 2022 and June 2022 revealed: -There was documentation of medication administration by Staff B on 05/31/22 at 7:00pm. -There was documentation of medication administration by Staff B on 06/01/22, 06/02/22, 06/14/22, 06/16/22, 06/21/22, and 06/23/22 at 7:00pm. Review of a second facility resident's eMARs, who resided in the memory care unit, for May 2022 and June 2022 revealed: -There was documentation of medication administration by Staff B on 05/31/22 at 8:00pm. -There was documentation of medication administration by Staff B on 06/01/22, 06/02/22, 06/07/22, 06/08/22, 06/ 09/22, 06/14/22, 06/16/22, 06/21/22, and 06/23/22 at 5:00pm and 8:00pm.	{D935}		

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{D935}	Continued From page 18 Review of a third facility resident's eMARs, who resided in the assisted living unit, for June 2022 revealed there was documentation of medication administration by Staff B on 06/04/22, 06/05/22, 06/10/22, 06/13/22, 06/18/22, 06/19/22, 06/22/22, 06/24/22 and 06/27/22 at 8:00pm. Interview with the Administrator on 06/29/22 at 12:28pm revealed: -The BOC was responsible for reviewing the registry before a person was hired to determine if the person was listed as a medication aide. -She was not aware Staff B had not taken and passed the state approved medication aide examination for adult care homes. -She thought if the staff was listed on the registry as a medication aide, that the staff had passed the test to administer medications in an adult care home. -She expected to be informed if a staff had not taken the state approved medication aide test so the staff could be signed up to take the test.	{D935}		