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	HAL076005	A. BUILDING: _____ B. WING _____	04/17/2024

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TERRABELLA ASHEBORO	2925 ZOO PARKWAY ASHEBORO, NC 27204

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D 000	Initial Comments The Adult Care Licensure Section and the Randolph County Department of Social Services (DSS) conducted an annual and follow-up survey from 04/16/24 to 04/17/24.	D 000		
D 156	10A NCAC 13F .0503 Medication Administration Competency 10A NCAC 13F .0503 Medication Administration Competency (a) The competency evaluation for medication administration required in Rule .0403 of this Subchapter shall consist of a written examination and a clinical skills evaluation to determine competency in the following areas: (1) medical abbreviations and terminology; (2) transcription of medication orders; (3) obtaining and documenting vital signs; (4) procedures and tasks involved with the preparation and administration of oral (including liquid, sublingual and inhaler), topical (including transdermal), ophthalmic, otic, and nasal medications; (5) infection control procedures; (6) documentation of medication administration; (7) monitoring for reactions to medications and procedures to follow when there appears to be a change in the resident's condition or health status based on those reactions; (8) medication storage and disposition; (9) regulations pertaining to medication administration in adult care facilities; and (10) the facility's medication administration policy and procedures (b) An individual shall score at least 90% on the written examination which shall be a standardized examination established by the Department. (c) Verification of an individual's completion of the written examination and results can be	D 156		

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D 156	Continued From page 1 obtained at no charge on the North Carolina Adult Care Medication Aide Testing website at https://mats.ncdhhs.gov/test-result. (d) The clinical skills validation portion of the competency evaluation shall be conducted by a registered nurse or a licensed pharmacist who has a current unencumbered license in North Carolina. The registered nurse or licensed pharmacist shall conduct a clinical skills validation for each medication administration task or skill that will be performed in the facility. Competency validation by a registered nurse is required for unlicensed staff who perform any of the personal care tasks related to medication administration listed in Subparagraphs (a)(4), (a)(7), (a)(11), (a)(14), and (a)(15) as specified in Rule .0903 of this Subchapter. (e) The Medication Administration Skills Validation Form shall be used to document successful completion of the clinical skills validation portion of the competency evaluation for those medication administration tasks to be performed in the facility employing the medication aide. The form requires the following: (1) name of the staff and adult care home; (2) satisfactory completion date of demonstrated competency of task or skill with the instructor's initials or signature; (3) if staff needs more training on skills or tasks, it should be noted with the instructor's signature; and (4) staff and instructor signatures and date after completion of tasks. Copies of this form and instructions for its use may be obtained at no cost on the Adult Care Licensure website, https://info.ncdhhs.gov/dhsr/acls/pdf/medchklst.pdf. The completed form shall be maintained and available for review in the facility and is not	D 156		

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D 156	Continued From page 2 transferable from one facility to another. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 6 sampled staff (Staff A and D), who administered medications, completed the 5, 10, or 15-hour medication aide (MA) training course or had verification of previous employment as a MA before administering medications to residents. The findings are: 1. Review of Staff A's medication aide (MA) personnel record revealed: -Staff A was hired on 11/15/22. -Staff A passed the written MA examination on 04/24/02. -There was no documentation Staff A completed the 5, 10, or 15-hour MA training. -There was no documentation or verification of previous employment as a MA. Review of a resident's February, March, and April 2024 electronic medication administration record (eMAR) revealed: -There was documentation Staff A administered medications on 5 days from 02/01/24 through 02/29/24. -There was documentation Staff A administered medications on 13 days from 03/01/24 through 03/31/24. -There was documentation Staff A administered	D 156		

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D 156	Continued From page 3	D 156		

medications on 8 days from 04/01/24 through 04/16/24.

Interview with Staff A on 04/17/24 at 10:50am revealed:
-She had passed the written MA examination in 2002.
-She had worked as a MA consistently since 2002 at various facilities.
-Upon hire to the facility, she completed training with another MA on the medication cart, but had not completed a 5, 10, or 15-hour MA training course.

Interview with the Senior Resident Care Coordinator (SRCC) on 04/17/24 at 11:20am revealed:
-She was not aware Staff A did not have an employment verification or a 5, 10, or 15-hour MA training course completion upon hire to the facility.
-Staff A was hired before she had taken over the responsibility of SRCC, so whoever was responsible for personnel records at the time of Staff A's hire would have been responsible for ensuring her training was completed.

Interview with the Administrator on 04/17/24 at 10:45am revealed she was not aware Staff A did not have a 5, 10, or 15-hour MA training upon hire or proof of employment as a MA since taking her written MA exam in 2002.

Refer to the interview with the SRCC on 04/17/24 at 11:20am.

Refer to the interview with the Administrator on 04/17/24 at 10:45am.

2. Review of Staff D's medication aide (MA)

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D 156	Continued From page 4	D 156		

personnel record revealed:
-Staff D was hired on 03/07/23.
-Staff D passed the written MA examination on 09/26/18.
-There was no documentation Staff D completed the 5, 10, or 15-hour MA training.
-There was no documentation or verification of previous employment as a MA.

Review of a resident's February, March, and April 2024 electronic medication administration record (eMAR) revealed:
-There was documentation Staff A administered medications on 8 days from 02/01/24 through 02/29/24.
-There was documentation Staff A administered medications on 6 days from 03/01/24 through 03/31/24.
-There was documentation Staff A administered medications on 2 days from 04/01/24 through 04/16/24.

Interview with the Senior Resident Care Coordinator (SRCC) on 04/17/24 at 11:20am revealed:
-She was not aware Staff D did not have an employment verification or a 5, 10, or 15-hour MA training course completion upon hire to the facility.
-Staff D was hired before she had taken over the responsibility of SRCC, so whoever was responsible for personnel records at the time of Staff A's hire would have been responsible for ensuring her training was completed.

Interview with the Administrator on 04/17/24 at 10:45am revealed she was not aware Staff D did not have a 5, 10, or 15-hour MA training upon hire or proof of employment as a MA since taking the written MA exam in 2018.

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D 156	Continued From page 5 Attempted telephone interview with Staff D on 04/17/24 at 11:15am was unsuccessful. Refer to interview with the SRCC on 04/17/24 at 11:20am. Refer to interview with the Administrator on 04/17/24 at 10:45am. Interview with the SRCC on 04/17/24 at 11:20am revealed: -She was responsible for personnel records and was responsible to ensure all required MA training and qualifications were completed. -She audited personnel records for required training components as different situations arose. Interview with the Administrator on 04/17/24 at 10:45am revealed: -The SRCC was responsible for ensuring all of the MAs completed the required training. -The SRCC was responsible for personnel records and had just started auditing personnel records one week ago. -She expected all MAs to complete the required training prior to working on the medication cart.	D 156		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing	D 161		

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D 161	Continued From page 6	D 161		

in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task.
(b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 1 of 6 sampled staff (Staff A) had been competency validated for licensed health professional support (LHPS) tasks including administering medications via machine by return demonstration.

The findings are:

Review of Staff A's medication aide (MA) personnel record revealed:
-Staff A was hired on 11/15/22.
-There was no documentation Staff A completed a LHPS competency validation checklist.

Review of a resident's February, March, and April 2024 electronic medication administration record (eMAR) revealed:
-There was documentation Staff A administered a nebulizer breathing treatment 4 times from 02/01/24 through 02/29/24.
-There was documentation Staff A administered a

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D 161	Continued From page 7	D 161		

nebulizer breathing treatment 14 times from 03/01/24 through 03/31/24.
-There was documentation Staff A administered a nebulizer breathing treatment 2 times from 04/01/24 through 04/05/24.

Interview with Staff A on 04/17/24 at 10:50am revealed:
-When she was hired at the facility in 2022, she remembered completing a skills checklist for MA tasks but did not know if she was checked off on LHPS tasks.
-As part of her job responsibilities as a MA, she administered nebulizer treatments along with other tasks such as checking fingerstick blood sugar (FSBS) levels, giving insulin injections, and applying oxygen therapy.
-Nobody at the facility had told her she needed to complete an additional skills checklist for LHPS tasks.

Interview with the Senior Resident Care Coordinator (SRCC) on 04/17/24 at 11:20am revealed:
-She was responsible for personnel records.
-She audited personnel records for required training components as different situations arose.
-She was not aware that Staff A did not have a LHPS skills competency validation checklist in her personnel record.
-Staff A was hired before she had taken over the responsibility of SRCC, so whoever was responsible for personnel records at the time of Staff A's hire would have been responsible for ensuring her training was completed.

Interview with the Administrator on 04/17/24 at 10:45am revealed:
-The SRCC was responsible for ensuring all the MAs completed the required training.

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D 161	Continued From page 8 -The SRCC was responsible for personnel records and had just started auditing personnel records one week ago. -She expected all MAs to complete the required LHPS tasks, after completion of the LHPS skills competency validation checklist. -She was not aware Staff A did not have a LHPS skills competency validation checklist in her personnel record.	D 161		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 5 sampled residents (Residents #1) who had refused daily weights. The findings are: Review of Resident #1's current FL2 dated 12/29/23 revealed diagnoses included congestive heart failure, lymphedema and chronic obstructive pulmonary disease. Review of Resident #1's physician order dated 12/28/23 revealed an order to check and record weight daily. Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry to check and record weight daily 7:00am to 3:00pm.	D 273		

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D 273	Continued From page 9 -There were 7 daily weights documented for 29 opportunities with weights from 291.2 to 295.2. -There were 21 of 29 opportunities documented as refused. -There was 1 day documented on 02/01/24 as the resident was out of the facility. Review of Resident #1's March 2024 eMAR revealed: -There was an entry to check and record weight daily 7:00am to 3:00pm. -There were 7 daily weights documented for 31 opportunities with weights from 271.4 to 293 pounds. -There were 20 of 31 opportunities documented as refused. -There were 4 days left blank on the eMAR. Review of Resident #1's 04/01/24-04/16/24 eMAR revealed: -There was an entry to check and record weight daily 7:00am to 3:00pm. -There were 9 daily weights documented for 16 opportunities with weights from 285.6 to 295 pounds. -There were 4 of 16 opportunities documented as refused. -There were 2 days left blank on the eMAR. Review of Resident #1's record revealed there was no documentation that the primary care provider (PCP) had been notified of his repeated refusals to obtain his daily weight. Review of the facility's refusal policy revealed: -When a resident refused a treatment, staff would notify the senior Resident Care Coordinator (RCC). -The senior RCC would then notify the PCP and the resident's responsible party.	D 273		

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D 273	Continued From page 10 -The senior RCC would then carry out orders or interventions. Interview with a medication aide (MA) on 04/16/24 at 3:40pm revealed: -She knew Resident #1 refused some daily weights often on first shift. -She worked second shift from 3:00pm to 11:00pm and he had not refused treatments from her. -If a resident refused care, medications or treatments, staff reported refusals to one of the Resident Care Coordinators (RCC). -The RCC would have been responsible for informing the PCP. -She had not needed to report any refusals from Resident #1 to the RCC or the PCP. Interview with a second MA on 04/17/24 at 8:15am revealed: -She did not work Resident #1's hall often but he had refused some daily weights in the past 3 months on first shift. -If a weight was due during the first shift, she would get busy and forget to go back and ask the resident to get the weight again. -After one refusal of care, medications or treatments by a resident, staff reported refusals to one of the Resident Care Coordinators (RCC). -The RCC would inform the PCP. -She did not report any refusals from Resident #1 to the RCC or the PCP. Interview with a third MA on 04/17/24 at 10:57am revealed: -Resident #1 refused his daily weights often in February and March 2024, but had been more compliant in April 2024. -He had CHF and had an order for a scheduled fluid pill.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 11	D 273		

-MAs reported refusals, after one refusal to the RCC.
-The RCC would report refusals to the PCP and inform MAs of any new orders.
-She had reported Resident #1's refusals to the RCC, but had not notified the PCP.

Interview with Resident #1 on 04/17/24 at 10:50am revealed:
-He had told staff that he did not feel like weighing when they asked when he was busy or did not feel like it.
-Most times, staff wanted to get his weight just before he left his room for lunch, and he did not want to do it at that time.
-The staff did not usually return and ask him to get his weight later in the shift.
-He did not realize there was an order from the PCP to get his weight every day due to his congestive heart failure (CHF) and he did not think it was a "big deal".

Interview with a third MA on 04/17/24 at 10:57am revealed:
-Resident #1 refused his daily weights often in February and March 2024, but had been more compliant in April 2024.
-He had CHF and had an order for a scheduled fluid pill.
-MAs report refusals, after one refusal to the RCC.
-The RCC would report refusals to the PCP and inform MAs of any new orders.
-She had reported Resident #1's refusals to the RCC, but had not notified the PCP.

Telephone interview with Resident #1's PCP on 04/17/24 at 11:15am revealed:
-Resident #1 had CHF and had scheduled furosemide 40mg (used to treat edema) 3 times a

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D 273	Continued From page 12	D 273		

day.
-He had a daily weight ordered and she expected staff to obtain his weight every day.
-Staff at the facility had not informed her that Resident #1 had refused daily weights most days in February, March and so far in April 2024.
-She had access to the facility's eMAR but had not reviewed his weights to see that he had refused.
-The facility had called 2 times in the past 2 to 3 weeks to report Resident #1 had complained of difficulty breathing and so she ordered him an as needed furosemide and/or another breathing treatment during those exacerbations.
-Having a daily weight to assess weight gain due to fluid buildup helped to prevent exacerbation.

Interview with the RCC on 04/17/24 at 1:20pm revealed:
-Resident #1 refused to be weighed daily frequently.
-MA were to report resident refusals after 2 times to her of the senior RCC (SRCC).
-She or the SRCC would report refusals to the resident's PCP.
-She expected MAs to obtain and record Resident #1's weight every day and inform her of his refusals.
-She had reported Resident #1's refusals to obtain his weight to the home health nurse, but had not reported it to his PCP.
-The PCP had access to the facility's eMAR and was able to view weights and refusals.

Interview with the SRCC on 04/17/24 at 1:10pm revealed:
-Resident #1 refused to be weighed daily frequently.
-MA were to report resident refusals after 3 times to her of the SRCC.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076005	A. BUILDING: _____ B. WING _____	04/17/2024

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D 273	Continued From page 13 -She or the SRCC would report refusals to the resident's PCP. -She expected MAs to obtain and record Resident #1's weight every day and inform her or the RCC of his refusals. -She knew the RCC had reported Resident #1's refusals to obtain his weight to the home health nurse. -She was not sure Resident #1's refusals had been reported to his PCP. -The PCP did have access to the facility's eMAR and was able to view weights and refusals. Interview with the Executive Director (ED) on 04/17/24 at 1:35pm revealed: -The facility's policy for refusal of medications and treatments required staff to report the refusals to the PCP and the responsible party after 3 refusals. -She expected MAs to report refusals to the PCP or one of the RCCs. -The RCC and SRCC would have been responsible to ensure notification of refusals to the PCP and carry out any new orders. -Resident #1 was difficult when he was asked to get his weights, but staff had all of first shift to obtain his weights and should have asked him 3 times during the shift before documenting refusal.	D 273		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the	D 366		

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D 366	Continued From page 14	D 366		

resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure medication aides observed residents taking their medications for 1 of 5 sampled residents (#3) who had medications in her room.

The findings are:

Review of Resident #3's current FL2 dated 11/27/23 revealed:
-Diagnoses included degenerative disc disease, gastroesophageal reflux disease (GERD), hyperlipidemia, irritable bowel syndrome (IBS), generalized anxiety disorder (GAD), and depression.
-There was an order for Benefiber chewable tablet (a fiber supplement) take 1 tablet daily.
-There was an order for buspirone (used to treat anxiety) 5mg daily.
-There was an order for Centrum Silver (a multiple vitamins and minerals tablet) 1 tablet daily.
-There was an order for prednisone (a steroid typically used to treat inflammation) 20mg daily.
-There was an order for Spironolactone (used to treat high blood pressure) 25mg daily.
-There was an order for Vascepa (used to treat hyperlipidemia) 2 grams twice daily.

Review of Resident #3's physician's order dated 01/16/24 revealed an order for famotidine (an antacid used to treat acid reflux) 20mg twice daily.

Review of Resident #3's physician's order dated

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D 366	Continued From page 15 01/22/24 revealed an order for omeprazole (a medication used to treat GERD) 40mg twice daily. Review of Resident #3's physician's order dated 02/15/24 revealed an order for finasteride (a medication to treat urinary retention) 5mg, take one-half tablet daily. Review of Resident #3's physician's order dated 03/01/24 revealed an order for Aspirin (a non-steroidal anti-inflammatory medication used to thin blood) 81mg daily. Review of Resident #3's physician's order dated 03/21/24 revealed an order for Escitalopram (a medication used to treat anxiety and depression) 5mg daily. Observation of Resident #3's room during the initial tour of the facility on 04/16/24 at 9:09am revealed: -Resident #3 was not in her room. -There was a side table next to the bed with two medication cups on it. -One medication cup contained 11 tablets and capsules and the other medication cup contained one large compressed powder tablet. -There were no staff present in Resident #3's room. Review of Resident #3's April 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Aspirin 81mg daily scheduled at 8:00am. -There was an entry for Benefiber chewable tablets take 1 tablet daily scheduled at 8:00am. -There was an entry for buspirone 5mg daily scheduled at 8:00am.	D 366		

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D 366	Continued From page 16 -There was an entry for Centrum Silver multivitamin, take 1 tablet daily scheduled at 8:00am. -There was an entry for Escitalopram 5mg daily scheduled at 8:00am. -There was an entry for famotidine 20mg twice daily scheduled at 8:00am and 8:00pm. -There was an entry for finasteride 5mg, take one-half tablet daily scheduled at 8:00am. -There was an entry for omeprazole 40mg twice daily scheduled at 8:00am and 8:00pm. -There was an entry for prednisone 20mg daily scheduled at 8:00am. -There was an entry for Spironolactone 25mg daily scheduled at 8:00am. -There was an entry for Vascepa 1 gram, take 2 capsules twice daily scheduled at 8:00am and 8:00pm. -There was documentation all of Resident #3's 8:00am medications had been administered on 04/16/24. Observation of Resident #3's room on 04/16/24 at 9:54am revealed: -Resident #3 was not in her room. -The medications on Resident #3's bedside table were no longer in the medication cups. Interview with Resident #3 on 04/16/24 at 10:27am revealed: -The medication aides (MA) usually left her morning medications on her bedside table for her to take whenever she returned to her room from eating breakfast. -It was her preference for the MAs to leave her medications in her room so that she could take them as soon as she finished eating breakfast so the medications would not upset her stomach. -Staff had never told her that they were not able to leave medications in her room.	D 366		

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D 366	Continued From page 17 -The MA did not watch her take her medications when she returned to her room from eating breakfast. -Usually the MA would check on her later in the morning to ask her if she took her morning medications. Interview with a personal care aide (PCA) on 04/17/24 at 10:20am revealed: -She worked throughout the entire facility. -She had never seen medications in a resident's room. -If she did see medications in a resident's room, she was responsible to notify the Resident Care Coordinator (RCC) or the Senior Resident Care Coordinator (SRCC). -Medications were not supposed to be left unsupervised in residents' rooms. Interview with the MA on 04/17/24 at 10:50am revealed: -When administering medications she prepared the resident's medications, watched the resident take the medications, and then documented the medication administration. -Some residents preferred to take their medications after breakfast so for those residents she would complete their medication administration when she saw they were back in their room from the dining room. -Resident #3 sometimes asked her to leave her morning medications in her room for her so she could take them on her own after breakfast, so she would. -Whenever she left medications in Resident #3's room, she always went back to check that Resident #3 took her morning medications and then documented that they were administered. -Resident #3 was the only resident she left medications in the room for.	D 366		

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D 366	Continued From page 18 Interview with the SRCC on 04/17/24 at 11:20am revealed: -The MAs were expected to observe each resident taking their medications prior to documenting the administration and moving on to the next resident. -She was not aware that Resident #3 had medications left in her room with no staff present. -Resident #3 was very aware of her medications and why she took each one, but she did not have an order to self-administer her medications so the MA should be observing her taking her medications. -If a resident wanted to take medications unsupervised, the MA should notify either herself or the RCC. Interview with the RCC on 04/17/24 at 1:20pm revealed: -MAs were not supposed to leave medications in residents' rooms. -All of the MAs were trained to observe each resident taking their medications. -If a resident did not want to take their medications at the time the MA was ready to give them their medication, the MA was expected to bring the medications back to the medication cart and destroy them. -If Resident #3 preferred to take her morning medications right after breakfast, she expected the MA to prepare her medications and observe Resident #3 taking them once she returned to her room from eating breakfast. -None of the staff had reported to her that Resident #3 was requesting the MAs leave medications in her room. -None of the PCAs had reported seeing medications in Resident #3's room.	D 366		

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D 366	Continued From page 19 Interview with the Administrator on 04/17/24 at 1:35pm revealed: -She was not aware that the MAs had been leaving Resident #3's morning medications in her room. -The MAs should all be watching each resident taking their medications prior to documenting the medication administration and moving on to the next resident. -The MA should have explained to Resident #3 why she was not able to leave her medications in her room unsupervised or reported it to the RCC or SRCC. -The MAs were all trained not to leave medications in resident rooms.	D 366		