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(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 an annual survey on June 22-23, 2017, with a telephone exit on June 26, 2017.	D 000		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's order for 2 of 5 sampled residents (Resident #5, and Resident #1) regarding obtaining daily blood pressure (BP) checks for Resident #5, and faxing weekly weights to the physician for Resident #1. The findings are: A. Review of Resident #5's current FL2 dated 12/18/16 revealed: -Diagnoses included hypertension and mild dementia. -A physician's orders to check BP every day. -A physician's order to fax BP results to MD monthly and fax BP results if diastolic blood pressure (DBP) was greater than 95 or less than 60 or if systolic blood pressure (SBP) was greater than 160 or less than 100.	D 276		

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D 276	Continued From page 1 Review of Resident #5's April 2017, May 2017, and June 2017 electronic Medication Administration Records (eMAR) revealed there was no entry for daily BP checks. Resident #5's BP on 06/23/17 was reported as 128/65. Interview on 06/23/17 at 10:30am with the day shift Medication Aide (MA) revealed: -Resident #5 received monthly BP checks rather than daily BP checks. -She was not aware that Resident #5 had an order for daily BP checks because it was not listed on his eMar. Interview on 06/23/17 at 11:28am with Resident #5's Hospice Registered Nurse (RN) revealed: -Resident #5 had begun receiving Hospice services on 10/24/16. -Resident #5 had been discharged from Hospice services on 6/14/17 due to him being "too stable" to receive Hospice services. -Hospice had not discontinued the physician's order for daily BP checks. Interview on 06/23/17 at 2:22pm with the Health and Wellness Director (HWD) revealed: -MAs, the Resident Care Coordinator (RCC) and the HWD could enter orders into the eMAR. -The facility switched from paper MARs to eMARs in March 2017. -The pharmacy was responsible for transferring orders from the paper MARs to the eMARs in March 2017. -The RCC and the HWD were responsible for confirming that the pharmacy had entered the orders into the eMARS correctly. -Resident #5's BP order was not transferred from	D 276		

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the paper MAR to the eMAR.
-The omission of Resident #5's BP order from the April 2017 eMAR was "missed" by both the pharmacy and the facility staff.

Interview on 06/23/17 at 3:05pm with the Executive Director revealed:
-MAs, the RCC and the HWD could enter orders into the eMAR.
-The facility switched from paper MARs to eMARs in March 2017.
-The pharmacy was responsible for transferring orders from the paper MARS to the eMARs in March 2017.
-The RCC was responsible for confirming the pharmacy had entered the orders into the eMARs correctly.
-Resident #5's BP order was not transferred from the paper MAR to the eMAR.
-The RCC responsible for confirming Resident #5s BP order was transferred from the paper MAR to the eMAR was no longer employed with the facility.

Telephone interview on 06/23/17 at 3:20pm with representative from Resident #5's physician's office revealed:
-Resident #5 had not been seen by his physician since October 2016 due to him being under the care of Hospice.
-They had not received any faxed BP results for Resident #5 in April 2017, May 2017, or June 2017.
-They were unaware that Resident #5's BP had not been checked daily as ordered.
-Resident #5's physician was out of town but would begin seeing Resident #5 again the following week due to him being discharged from Hospice.

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D 276	Continued From page 3 Based on review of Resident #5's record, interviews with staff and attempted interview with Resident #5, it was determined the resident was not interviewable. B. Review of Resident #1's current FL2 dated 11/01/16 revealed: -Diagnoses included anxiety, psychosis, and hypertension. -A physician's order for weekly weights and fax MD (physician) weekly. Review of Resident #1's subsequent physician's orders revealed: -Signed physician's orders in January 2017 (no date included) continuing "Check weight once weekly-fax results to MD weekly in the morning every Wed [Wednesday] related to ESSENTIAL (PRIMARY) HYPERTENSION". -There was no subsequent physician's order regarding faxing weekly weights to Resident #1's physician. Review of Resident's #1's progress notes revealed no documentation Resident #1's weights had been faxed to the physician weekly as ordered. Review of Resident #1's April 2017, May 2017 and June 2017 electronic Medication Administration Records (eMARs) revealed: -An entry for "Check weight once weekly-fax results to MD weekly in the morning every Wed [Wednesday] related to ESSENTIAL (PRIMARY) HYPERTENSION", and scheduled for 8:00 am on Wednesdays. -The eMARS had a space for documenting the Medication Aide (MA) that obtained the weights' signatures but no space for documenting the	D 276		

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weight value.
-There was documentation of weights obtained by the MA on the eMARS on Wednesdays in each month by the same Medication Aide.
-The MAs obtained all of the weights and Resident #1's weight was documented four times in April 2017, 5 times in May 2017, and 3 times in June 2017.
-There was no documentation on the eMARs related to weight results faxed to the physician weekly as ordered.

Review of the MAs daily "Residents' notes" revealed:
-In April 2017 weights were documented 4 times on a Wednesday with a value of 210 pounds.
-In May 2017 weights were documented 5 times on a Wednesday with a range of 210 pounds to 215 pounds.
-In June 2017 weights were documented 3 times on a Wednesday with a value of 215 pounds.

Interview on 06/22/17 at 2:47 pm with the Health and Wellness Director (HWD) revealed:
-She had been in her current position since October 2016.
-The MAs were responsible to administer medications and perform treatments as ordered, and to document administration of medications or completion of treatments, ordered by a physician or provider, for residents on the residents' eMARs, in the medication computers' electronic progress notes, or in the resident's record.
-She was unable to locate documentation in Resident #1's record the resident's weight was faxed to the physician weekly (or at all).
-Review of Resident #1's computer progress notes revealed no documentation for Resident #1's weekly weights faxed to the physician as ordered.

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-She had not audited the resident's record for implementation of the order to fax Resident #1's weight to the physician's office weekly.

Interview on 06/23/17 at 3:38 pm with Resident #1 revealed:
-Staff obtained his weight often, but he was not sure if weekly.
-His weight had been very stable lately.
-He did not have increased swelling anywhere on his body.
-He was not sure how often staff were to weigh him.
-His physician came to the facility weekly.
-He saw his physician, at the facility, frequently but not every week.

Interview on 06/23/17 at 3:45pm with the Executive Director revealed:
-The RCC and HWD were responsible for assuring physician's orders were implemented.
-The HWD would be responsible for assuring MAs administered medications and treatments as ordered and documented in the resident's record or medication computer system.

Telephone interview on 06/26/17 at 9:25am with Resident #1's primary physician's nurse revealed:
-The physician's office had no documentation for the facility faxing Resident #1's weight weekly.
-The physician visited the facility where Resident #1 was residing weekly.
-There was no documentation the physician had changed the order for Resident #1's weight to be faxed weekly.
-The physician was going to change the order to weigh Resident #1 monthly and fax the results to physician.

-Telephone interview on 06/26/17 at 9:35 am with

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D 276	Continued From page 6 the MA documenting Resident #1's weights weekly revealed: -She did weigh Resident #1 weekly on Wednesday, as ordered. -She documented the weights in a personal Resident's note book that she kept with her all the time when she was at work. -She left the Resident's note book at work when she left but kept it in a secure place. (Copies of the MA's resident notes were reviewed on 06/26/17). -She had been taking Resident #1's weekly weight for more than a year. -She would have faxed Resident #1's physician notification of any significant weight change (4-5 pounds) from one week to the next. -Resident #1's physician had access to the MA's Resident notes when she was at the facility on Tuesday each week. -She had not faxed Resident #1's weights to his physician as ordered because the resident's weight had not changed much in several months.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure nutritional supplements were served as ordered by a physician for 1 of 5 sampled residents (Resident	D 310		

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D 310	Continued From page 7 #5). The findings are: Review of Resident #5's current FL2 dated 12/18/16 revealed: -Diagnoses included hypertension and mild dementia. -A physician's order for a nutritional supplement shake twice daily. Review of Resident #5's April 2017, May 2017, and June 2017 electronic Medication Administration Records (eMAR) revealed there was no entries for a nutritional supplement shake to be given twice daily. Observation on 06/23/17 at 8:00am of medication cart revealed: -Nutritional supplement shakes in a cooler. -Nutritional supplement shakes being administered to other residents with their medications. Interview on 06/23/17 at 10:30am with the morning shift Medication Aide (MA) revealed: -MAs were responsible for providing nutritional supplement shakes to residents during medication administration times if the resident had an order for nutritional supplement shakes in their eMAR. -Resident #5 had been receiving nutritional supplement shakes at one time. -Resident #5 had not received a nutritional supplement shake that morning because the order had not shown on his eMAR. -She could not recall the last time Resident #5 received a nutritional supplement shake. Interview on 06/23/17 at 11:28am with Resident	D 310		

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#5's Hospice Registered Nurse (RN) revealed:
-Resident #5 had began receiving Hospice services on 10/24/16.
-Resident #5 had been discharged from Hospice services on 6/14/17 due to him being "too stable" to receive Hospice services.
-Hospice had not discontinued the physician's order for a nutritional supplement shake to be given twice daily.

Interview on 06/23/17 at 2:22pm with the Health and Wellness Director (HWD) revealed:
-MAs, the Resident Care Coordinator (RCC) and the HWD could enter orders into the eMAR.
-The previous RCC had entered the order for a nutritional supplement shake to be given twice daily into the computer system incorrectly under "other orders".
-Orders listed in the computer system under the "other orders" category would not show up on the eMAR where MAs could see them.
-MAs could only administer nutritional supplement shakes if an order showed up on the eMAR where they could see it.

Interview on 06/23/17 at 3:05pm with the Executive Director revealed:
-MAs, the RCC and the HWD could enter orders into the eMAR.
-The previous RCC had entered the order for nutritional supplement shakes to be given twice daily into the computer system incorrectly under "other orders".
-Orders listed in the computer system under the "other orders" category would not have shown up on the eMAR where MAs could see them.
-MAs could only administer nutritional supplement shakes if an order showed up on the eMAR where they could see it.
-The RCC responsible for entering the physician's

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D 310	Continued From page 9 order incorrectly for a nutritional supplement shake to be given twice daily was no longer employed at the facility. Telephone interview on 06/23/17 at 3:20pm with representative from Resident #5's physician's office revealed: -Resident #5 had not been seen by his physician since October 2016 due to him being under the care of Hospice. -Resident #5's physician was out of town but would begin seeing Resident #5 again the following week due to him being discharged from Hospice. Based on review of Resident #5's record, interviews with staff and attempted interview with Resident #5, it was determined the resident was not interviewable.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure Novolog Insulin was administered as ordered by the licensed prescribing practitioner for 1 of 3 sampled	D 358		

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D 358	Continued From page 10 residents (Resident #4) with orders for finger-stick blood sugar (FSBS) monitoring checks and insulin administration. Review of Resident #4's current FL2 dated 9/28/16 revealed: -Diagnoses included altered mental status, transient ischemic attack. -There was no documentation of a diagnosis for diabetes on the current FL2. Review of a physician's order page dated 1/23/17 revealed a diagnosis of diabetes. Review of Resident #4's subsequent physician's orders revealed: -A physician's order dated 9/29/16 for FSBS checks three times a day, but no parameters were ordered. -A physician's order dated 10/17/16 for FSBS parameters to call physician if blood sugar (BS) result was less than 70 or greater than 300. -A physician's order dated 12/07/16 for Humalog (a rapid acting insulin) 5 units if BS was over 300; retake in 3 hours, if BS was still over 230 give 3 more units, and if BS was under 230, give nothing. -A physician's order page dated 1/23/17 for fasting FSBS every Monday, Wednesday and Friday at 8:00 am. -A physician's order dated 1/23/17 for FSBS every night before dinner and "to continue with current insulin orders". -A physician's order dated 4/19/17 to change Humalog to Novolog (a rapid acting insulin), with the same doses and parameters ordered. -A physician's order dated 6/19/17 to change the Novolog parameter order to "if the repeated BS is less than 230, to give no insulin".	D 358		

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D 358	Continued From page 11 Review of a laboratory report dated 2/17/17 revealed: -A laboratory blood test result of a hemoglobin A1C (HgA1C) level of 7.4% (normal range >6.4% for diabetics, and used to measure BS control) from a blood sample taken on 2/14/17. -Previous HbA1C results were included from 4/09/15 to 2/14/17 that ranged from 6.7 to 7.4. -A physician notation that "HgA1C is elevated but much better". Review of Resident #4's April 2017 electronic Medication Administration Record (eMAR) revealed: -An entry to "monitor blood glucose in the morning every Monday, Wednesday and Friday" at 7:00 am with results documented as ordered and ranging from 107 to 138. -An entry to "monitor blood glucose in the afternoon (and scheduled at 5:00 pm). Give 5 units Novolog if BS is over 300, recheck in 3 hours; if over 230, give 3 more units of Novolog; if under 230, give nothing". Documented BS results ranging from 102 to 387. -An entry for Humalog 5 units at 5:00 pm if BS "is over 300. Retake in 3 hours, if BS is still over 230 give 3 more units, and if BS is under 230 give nothing". This entry was discontinued on 4/20/17. -An entry with a start date of 4/20/17 for Novolog 5 units "as needed for elevated blood sugar. Give 5 units if BS is over 300; recheck in 3 hours, if over 230, give 3 more units, if under 230, give nothing". -An entry with a start date of 4/20/17 for Novolog 3 units "as needed for elevated blood sugar. If after 3 hour recheck, BS is over 230, administer 3 units". -Documented BS results were greater than 300 and required insulin administration and BS rechecks for 7 of 30 days as follows:	D 358		

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D 358	Continued From page 12 -On 4/17/17 Novolog 5 units was documented as administered for a BS result of 342, but no BS recheck result was documented. -On 4/18/17 Novolog 5 units was documented as administered for a BS result of 349. A BS recheck result of 176 was documented on 4/18/17 at 9:10 pm. -On 4/20/17 a BS result of 311 was documented but no insulin was administered and no BS recheck result was documented. -On 4/22/17 Novolog 5 units was documented as administered for a BS result of 374. A BS recheck result of 169 was documented on 4/22/17 at 6:41 pm. -On 4/24/17 Novolog 5 units was documented as administered for a BS result of 387. A BS recheck result of 189 was documented on 4/24/17 at 7:36 pm. -On 4/25/17 Novolog 5 units was documented as administered for a BS result of 311. A BS recheck result of 145 was documented on 4/25/17 at 6:54 pm. -On 4/28/17 Novolog 5 units was documented as administered for a BS result of 332. A BS recheck documentation as "effective" on 4/28/17 at 7:17 pm but no numerical BS result was documented. -Insulin was documented as administered when it was not required, not administered when it was required, and/or no BS recheck results were documented for 5 of 30 days as follows: -Humalog 5 units was documented as administered on 4/16/17 at 5:00 pm for a BS result of 256. No insulin should have been administered. No BS recheck was required or documented as having been performed. -Humalog 5 units was documented as administered on 4/17/17 at 5:00 pm for a BS result of 342. No BS recheck result was documented. -A BS result of 311 was documented on 4/20/17	D 358		

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but no insulin was documented as being administered and no BS recheck result was documented. Novolog 5 units should have been administered. There was no documentation why insulin was not administered and a recheck was not obtained.
-Novolog 5 units was documented as administered on 4/26/17 at 4:25 pm for a BS result of 271. No insulin should have been administered, and a BS recheck was not required. A BS recheck result of 74 was documented on 4/26/17 at 8:07 pm.
-Novolog 3 units was documented as administered on 4/29/17 at 4:14 pm for a BS result of 298. No insulin should have been administered, and a BS recheck was not required. A BS recheck result of 171 was documented on 4/29/17 at 7:45 pm.

Review of Resident #4's May 2017 eMAR revealed:
-An entry to "monitor blood glucose in the morning every Monday, Wednesday and Friday" at 7:00 am with results documented as ordered and ranging from 112 to 145.
-An entry to "monitor blood glucose in the afternoon (and scheduled at 5:00 pm). Give 5 units Novolog if BS is over 300, recheck in 3 hours; if over 230, give 3 more units of Novolog; if under 230, give nothing". Documented BS results ranging from 91 to 323.
-An entry for Novolog 5 units "as needed for elevated blood sugar. Give 5 units if BS is over 300; recheck in 3 hours, if over 230, give 3 more units, if under 230, give nothing".
-An entry for Novolog 3 units "as needed for elevated blood sugar. If after 3 hour recheck, BS is over 230, administer 3 units".
-The BS results were greater than 300 and required insulin administration and BS rechecks

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for 3 of 31 days as follows:
-On 5/07/17 Novolog 5 units was documented as administered for a BS result of 323. A BS recheck result of 207 was documented on 5/07/17 at 7:12 pm.
-On 5/11/17 Novolog 5 units was documented as administered for a BS result of 301. A BS recheck result of 101 was documented on 5/11/17 at 7:29 pm.
-On 5/27/17 Novolog 5 units was documented as administered for a BS result of 319. A BS recheck documentation as "effective" on 5/27/17 at 7:29 pm but no numerical BS result was documented.
-Insulin was documented as administered when it was not required and/or no BS recheck results for 3 of 31 days as follows:
-Novolog 5 units was documented as administered on 5/13/17 at 4:20 pm for a BS result of 271. No insulin should have been administered, and a BS recheck was not required. A BS recheck result of 154 was documented on 5/13/17 at 7:09 pm.
-Novolog 3 units was documented as administered on 5/25/17 at 4:29 pm for a BS result of 291. No insulin should have been administered, and a BS recheck was not required. A BS recheck result of 214 was documented on 4/29/17 at 7:17 pm.
-Novolog 5 units was documented as administered on 5/28/17 at 4:21 pm for a BS result of 290. No insulin should have been administered, and a BS recheck was not required. A BS recheck result of 131 was documented on 5/28/17 at 6:57 pm.

Review of Resident #4's June 2017 eMAR from 6/01/17 to 6/22/17 revealed Novolog insulin was administered when required for 3 of 21 days and with the BS rechecked as ordered. There were no errors with insulin administration for the month of

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D 358	Continued From page 15 June 2017. Review of Resident #4's medication on hand on 6/22/17 at 4:15 pm revealed Novolog insulin, a glucometer labeled with Resident #4's name and in a case with FSBS testing supplies, and single use syringes were available. Interview on 6/23/17 at 8:15 am with the Health and Wellness Director (HWD) revealed: -She had worked at the facility as the HWD since October 2017. -She was not aware the Medication Aides (MA) had administered insulin to Resident #4 when the BS was less than 300. -Resident #4 was to received insulin only if her BS was >300. -The MAs were to ask the HWD or the physician if they had questions about any orders. Interview on 6/23/17 at 10:00 am with Resident #4 revealed: -She received insulin if her BS was greater than 300 before her dinner meal only. -The staff rechecked her BS and if it was still elevated, she would get more insulin, but that had not been necessary. -The staff were "giving my insulin correctly", and reported to her what her BS result was. Interview on 6/23/17 at 10:05 am with Resident #4's physician revealed: -Resident #4 was to be administered insulin only if her BS was greater than 300 at the dinner meal, and then if it was still greater than 230 after 3 hours, she was to be given more insulin. -He was not aware she had been given insulin for BS results less than 300, 6 times in the past 3 months, and stated "that is an error". -Resident #4's HgA1C "was well controlled", so	D 358		

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D 358	Continued From page 16 he did not plan to change her orders. -The facility should follow his orders and contact him if there was any confusion. Interview on 6/23/17 at 10:20 am with the Executive Director revealed she was not aware staff were not administering insulin as ordered to Resident #4, but expected physician orders to be followed. Interview on 6/23/17 at 10:30 am with a MA revealed: -She had worked at the facility greater than one year as a MA. -She did not administer insulin to Resident #4 in the morning. -Resident #4 was to have her BS checked before her dinner meal and be given insulin if her BS was greater than 300 only. If Resident #4's BS was 290, she was not to be given any insulin. -If she had any questions about a physician's order, she was to either ask the HWD or to call the physician (or ask if he was in the building) who wrote the order.	D 358		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home 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:	D935		

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D935	Continued From page 17 (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. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 1 of 2 sampled Medication Aides (Staff C) had completed the Medication Administration Clinical Skills Validation and the 5, 10 or 15 hours of Madication Aide training prior to administering medications.	D935		

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D935	Continued From page 18 The findings are: Review of Staff C's personnel records revealed: -She was hired on 1/06/15 as a Medication Aide (MA) -Documentation Staff C passed the written Medication Administration exam on 6/24/14. -There was no documentation Staff C completed a Medication Clinical Skills Checklist. -There was no documentation that Staff C completed the 5, 10, or 15 hours of MA training. Review of residents' electronic Medication Administration Records revealed Staff C documented administration of medications in April, May, and June 2017 to residents including Fingerstick Blood Sugar monitoring and insulin administration. Observation of Staff C on 2/23/17 at 8:32am revealed Staff C was at the medication cart preparing medications and administered medications to residents. Interview with Staff C on 2/23/17 at 2:15pm revealed: -She had been employed at the facility for around two years as a MA -She had been a MA at her last place of employment, but she did not have a MA employee verification. -She had completed the Clinical Skills Checklist for medication administration after start of employment at this facility. -The Registered Nurse who validated her clinical skills at this facility was no longer employed there (at the facility). -She did not have a copy of her validated Clinical Skills Checklist.	D935		

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D935	Continued From page 19 -"They should have it here somewhere." Interview with the Health and Wellness Director on 2/23/17 at 2:46 pm revealed: -She had been employed at the facility since October 2016. -She had not been able to locate a copy of Staff C's completed Clinical Skills Checklist. -She would be the person responsible at this time for validating the Clinical Skills Checklist. -"The former Health and Wellness Director completed it before I got here and she is no longer here." -"I can check her off before she goes back on the cart." Interview with the Administrator on 2/23/17 at 3:50pm revealed: -She was not aware prior to today that Staff C's completed Clinical Skills Checklist was not on file in her personnel records. -The Health and Wellness Director was responsible for completing the Clinical Skills Checklist prior to Medication Aides administering medications after hire. -A Clinical Skills Checklist would be completed by the Health and Wellness Director prior to Staff C administering medications again.	D935		