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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 and the Buncombe County Department of Social Services conducted an annual and follow-up survey on October 29, 2019 and October 30, 2019.	D 000		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 3 of 7 sampled residents (#4, #6 & #7) were tested for tuberculosis (TB) disease. The findings are: 1. Review of Resident #4's current FL2 dated 09/09/19 revealed diagnoses included benign prostatic hyperplasia, osteoarthritis, hypertension, gait disturbance, diabetes, and left eye blindness. Review of the Resident Register for Resident #4	D 234		

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revealed an admission date of 09/06/18.

Review of Resident #4's immunization record revealed there was no documentation of TB skin testing.

Interview with Resident #4 on 10/29/19 at 4:00pm revealed:
-His TB skin tests had all been negative.
-He had not received TB skin testing when he was admitted to the facility.
-He had a chest x-ray to rule out pneumonia during a hospital stay prior to moving into the facility.

Refer to the interview with the Facility Nurse on 10/29/19 at 9:00am.

Refer to the interview with the Administrator in Training (AIT) on 10/30/19 at 2:00pm.

Refer to the interview with the Interim Executive Director (ED) on 10/30/19 at 2:09pm.

2. Review of Resident #6's current FL2 dated 07/22/19 revealed diagnoses included chronic kidney disease, dysphagia, and muscle weakness.

Review of the Resident Register for Resident #6 revealed an admission date of 05/26/18.

Review of Resident #6's immunization record revealed there was documentation of two tuberculosis (TB) skin testing on 05/26/18 and 06/09/18 with no results recorded.

Interview with Resident #6 on 10/30/19 at 2:55pm revealed he remembered having TB skin testing, but it was not when he was admitted to the

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D 234	Continued From page 2 facility. Interview with the Facility Nurse on 10/30/19 at 12:00pm revealed she had not reviewed Resident #6's TB skin testing because it was completed prior to her being hired at the facility. Refer to the interview with the Administrator in Training (AIT) on 10/30/19 at 2:00pm. Refer to the interview with the Interim Executive Director (ED) on 10/30/19 at 2:09pm. 3. Review of Resident #7's current FL2 dated 09/12/19 revealed diagnoses included hypoxic respiratory failure, chronic obstructive pulmonary disease (COPD), and cervical reticulitis. Review of the Resident Register for Resident #7 revealed an admission date of 09/10/19. Review of Resident #7's immunization record revealed there was no documentation of tuberculosis (TB) skin testing. Interview with Resident #7 on 10/30/19 at 12:30pm revealed: -She had TB skin tests prior to her admission and they had been negative. -She had not received TB skin testing when she was admitted to the facility. -She had a chest x-ray during an exacerbation of COPD. Refer to the interview with the Facility Nurse on 10/30/19 at 9:00am. Refer to the interview with the Administrator in Training (AIT) on 10/30/19 at 2:00pm.	D 234		

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D 234	Continued From page 3 Refer to interview with the Interim Executive Director (ED) on 10/30/19 at 2:09pm. Interview with the Facility Nurse on 10/30/19 at 9:00am revealed: -She was responsible for ensuring the residents had their TB skin testing upon admission. -Since she had started at the facility about a month ago, she had begun auditing the residents' records. -She did not know the residents required TB skin tests if they had a chest x-ray. Interview with the Administrator in Training (AIT) on 10/30/19 at 2:00pm revealed: -She was the Director of Sales and Marketing prior to beginning her training to become the Administrator in Training. -When she was the Director of Sales and Marketing, she would inform residents at the time of admission they were required to complete TB skin testing. -All completed TB skin tests were given to the clinical staff to review them. -The clinical staff was responsible for ensuring all the residents had completed their TB skin testing. Interview with the Interim Executive Director (ED) on 10/30/19 at 2:09pm revealed: -She knew the residents required TB skin testing. -The clinical staff responsible for ensuring the TB skin testing was completed for each resident was no longer working at the facility. -There was no excuse for why the residents did not have their TB skin testing upon admission. The facility failed to ensure Resident #4, #6, and #7 received TB skin testing upon admission. This failure placed all residents at risk of TB disease and was detrimental to the health, safety and	D 234		

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D 234	Continued From page 4 welfare, and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/19 for this violation. CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 13, 2019.	D 234		
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 assure physician notification for 1 of 7 sampled residents (Resident #6) related to refusals of a scheduled laxative medication. The findings are: Review of Resident #6's current FL2 dated 07/22/19 revealed: -Diagnoses included chronic kidney disease, muscle weakness, hypertension, and dysphagia. -There was a physician's order for lactulose 10gm/15ml take 15mls at bedtime for	D 273		

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constipation (used as a laxative to treat chronic constipation).

Review of Resident #6's September 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for lactulose 10gm/15ml take 15mls at bedtime for constipation scheduled to administer at 9:00pm.
-Lactulose was documented as refused for 22 out of 30 opportunities from 09/01/19 to 09/30/19.

Review of Resident #6's October 2019 eMAR revealed:
-There was a computer-generated entry for lactulose 10gm/15ml take 15mls at bedtime for constipation scheduled to administer at 9:00pm.
-Lactulose was documented as refused for 25 out of 29 opportunities from 10/01/19 to 10/29/19.

Observation of medications on hand for Resident #6 on 10/30/19 at 11:45am revealed:
-There was an opened, full 473 ml bottle of lactulose 10gm/15ml dispensed on 09/18/19 with the directions to take 15ml daily at bedtime.
-The bottle had a note written on the label indicating the bottle was opened 10/10/19.

Interview with Resident #6 on 10/30/19 at 2:55pm revealed:
-He did not remember refusing any medications.
-He listened to the physician assistants (PA) and did what they told him.
-He took diuretics to help remove excess fluid and it made it hard to "use the bathroom."
-He did not know he was not receiving the laxative.

Review of Resident #6's record revealed no documentation the facility staff had contacted the

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provider regarding medication refusals.

Telephone interview with a nurse from Resident #6's primary care provider's office on 10/30/19 revealed:
-The facility had not contacted the office related to Resident #6 refusing medications.
-Resident #6 was prescribed lactulose to treat chronic constipation and he had a history of having abdominal distention.

Interview with a medication aide (MA) on 10/30/19 at 11:45am revealed:
-She did not know Resident #6 was refusing his lactulose on most days.
-She did not have trouble getting Resident #6 to take his medication.
-Resident #6 was complaining of constipation today and asked for some prune juice.
-The MAs were responsible for contacting the provider about a resident refusal to take a medication.
-The facility policy was to call the provider if a resident refused a medication after 3 consecutive days.
-The primary care provider came to the facility weekly to see residents.
-She would usually just make a note to let them know if a resident was refusing a medication.
-She had never been told to document when she talked with a provider related to medication refusals.

Interview with the MA Supervisor on 10/30/19 at 2:45pm revealed:
-She did not know Resident #6 was refusing his lactulose.
-The MAs were responsible for contacting the resident's provider after 3 consecutive refusals.
-The MAs were responsible for documenting on

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the eMAR if they had contacted a provider regarding an issue with a resident.

Interview with the Interim Health Care Coordinator (HCC) on 10/30/19 at 12:01pm revealed:
-She did not know Resident #6 was refusing the lactulose.
-The resident's provider should be contacted immediately once a resident refuses a medication.
-The Facility Nurse should also be informed of all residents that were refusing medications.

Interview with the Facility Nurse on 10/30/19 at 12:19pm revealed:
-She did not know Resident #6 was refusing his lactulose on most days.
-The MAs were responsible for contacting a resident's provider regarding medication refusals as soon as possible after the refusal.

Interview with a physician assistant (PA) from Resident #6's primary care provider's office on 10/30/19 at 2:30pm revealed:
-He did not know Resident #6 was refusing the lactulose almost daily.
-An MA "had probably" talked with him about it when he was in the facility.
-Resident #6 needed to take his medication every day as prescribed.
-They had just increased the dose of another medication for constipation because Resident #6 "must have been complaining" with constipation.
-The facility was responsible for calling the provider if a resident was refusing medications because it was important to know to adjust medication and treat the resident.

Interview with the interim Executive Director on

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D 273	Continued From page 8 10/30/19 at 3:45pm revealed: -She did not know Resident #6 was refusing lactulose. -The MAs were responsible for calling the provider for guidance on how to handle a resident refusing medications. -The MAs were responsible for contacting the provider after 3 consecutive medication refusals. -The MAs were responsible for notifying the Facility Nurse.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure food being stored in the kitchen refrigerator, freezer and dry food storage was protected from contamination related to unlabeled and undated food and expired food items not being discarded timely. The findings are: Review of the local Environmental Health sanitation report dated 10/03/19 revealed an inspection score of 96. Observation of the locked unit kitchen area on 10/29/19 at 3:10pm revealed: -There were eleven 32-ounce cartons of vanilla	D 283		

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D 283	Continued From page 9 flavored liquid supplement with use by date of 07/14/19 on each carton located on a metal stand in the kitchen. -There was one 32-ounce thickened dairy drink with use by date of 07/09/19 on the carton located on a metal stand in the kitchen. Observation of the first floor kitchen freezer on 10/29/19 at 3:23pm revealed: -There was 1 opened 3-pound bag of breaded okra with less than 25% remaining in the bag with no date or label. -There was 1 opened 40-ounce bag of beer battered onion rings with less than 25% remaining in the bag with no date or label. -There was 1 opened 2-pound bag of fried green tomatoes with more than 75% remaining in the bag with no date or label. Observation of the first floor kitchen refrigerator on 10/29/19 at 3:27pm revealed: -There were three previously prepared mixed salads with lettuce, tomato, cucumbers and onions on three individual salad plates open to air with no cover and no label or date. -There was 1 opened 5-pound bag of cheddar cheese open to air with no date or label. -There were two 32-ounce containers of non-fat plain Greek yogurt, one unopened and one opened, both with an expiration date of 09/28/19. -There was one 32-ounce container of non-fat plain Greek yogurt with an expiration date of 09/28/19 had a label indicating it was opened on 10/13/19 and should be used by 10/18/19. Observation of the first floor kitchen dry food storage on 10/29/19 at 3:34pm revealed: -There was 1 opened 5-pound bag of quick dry grits with less than 25% remaining with no date when it was opened.	D 283		

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D 283	Continued From page 10 -There were three 1-pound boxes of fettuccine open to air due to what appeared to be damage to the exterior of the boxes. Interview with the Dietary Manager on 10/30/19 at 2:30pm revealed: -He was unaware food was not being labeled and dated correctly or expired food items had not been discarded. -He checked the kitchen for labeled and dated items several times each week but was off the previous week and had not checked the freezer, refrigerator or dry storage area since his return the previous day. -All the kitchen staff should have been labeling and dating items once opened and discarding items that had expired. -He was responsible to verify the labeling and dating was being done as well as assuring expired items were discarded. Interview with the Administrator on 10/30/19 at 3:48pm revealed: -She was unaware there were unlabeled, undated food items in the refrigerator, freezer and dry food storage and that expired items had not been discarded. -All food products should have been labeled, dated and in a sealed container after being opened. -Dates should have been checked daily on food products so there was no oversight of expired items that needed to be discarded. -Ultimately the Dietary Manager was responsible to assure this is being done.	D 283		
D 366	10A NCAC 13F .1004 (i) Medication Administration	D 366		

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D 366	Continued From page 11 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 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, interviews and record review, the facility failed to assure medication aides observed residents take their medications after administration for 1 of 7 sampled residents (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 02/05/19 revealed diagnoses included osteoporosis and vitamin D deficiency. Observation on 10/29/19 at 10:30am revealed: -Resident #1 was sitting on a couch in her living room area. -There was a table directly in front of Resident #1. -There was a plastic medication cup with one green tablet setting on the table. Review of Resident #1's physician orders revealed an ordered dated for 11/07/17 for calcium antacid 500mg chewable tablet. Observation on 10/30/19 at 9:24am with the	D 366		

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D 366	Continued From page 12 Medication Aide (MA) in Resident #1's room revealed: -The plastic medication cup with one green tablet was sitting on the table in the living room. -This medication is an antacid that Resident #1 takes daily. -Resident #1 was awake but lying in bed. -At Resident #1's bedside table was a plastic medication cup with 3 peach and 1 pink colored tablet in . -The MA informed Resident #1 that she could not keep these medications in her room and removed the 4 tablets from the bedroom and the 1 tablet from the living room. Interview on 10/30/19 at 9:33am with the MA revealed: -The tablets found in Resident #1's room were TUMS. -She gave Resident #1 her medications this morning. -She observed Resident #1 chew her tablet this morning. -She did not observe the tablet in the living room or the tablets in the bedroom this morning. -She had been trained not to leave medications with the resident. -She always observed each resident take medications and had never left a resident with medication in the room unless they could self-administer medication. -Resident #1 did not have an order to self-administer her calcium antacid. Interview on 10/30/19 at 9:45am with the Regional Corporate Nurse revealed: -Staff giving medications should not leave them with the resident. -Staff needed to make sure the medication was taken before leaving the room.	D 366		

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D 366	Continued From page 13 Interview on 10/30/19 at 10:35am with the Interim Executive Director (ED) revealed: -The staff administering medications were given instructions during orientation not to leave medications with a resident. -Part of the orientation training included medication expectations and standards that indicated "Medications being administered must not be left with a resident, you must observe medication consumption." Interview on 10/30/19 at 2:10pm with Resident #1 revealed: -She did not keep medication in her bedroom. -She did not know why she was taking an antacid in the first place since she never had heartburn. -Staff usually stayed in the room while she took her medications, but not always. -She had skipped taking her antacid at least 3 times in the past week. -She had told the staff that she would take her antacid later and they left it with her. Interview on 10/30/19 at 3:50pm with the Administrator In Training (AIT) revealed: -She expected staff to take medications into the resident's room and observe the residents take all medications before leaving the room. -Staff should never leave the medication in the room with the resident and assume it was taken. -She was not aware staff were leaving medication in Resident #1's room.	D 366		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are	D912		

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	HAL011361	A. BUILDING: _____ B. WING _____	R 10/30/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CROSSINGS AT REYNOLDS MOUNTAIN	41 COBBLERS WAY ASHEVILLE, NC 28804

(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
D912	Continued From page 14 adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to ensuring the medications aides were appropriately trained by completing the Medication Administration Skills Validation and the 5, 10 or 15 medication aide training, and ensuring all residents were tested for tuberculosis upon admission. The findings are: 1. Based on interviews and record reviews, the facility failed to ensure 3 of 7 sampled residents (#4, #6 & #7) had completed tuberculosis testing upon admission in compliance with the control measures for the Commission for Health Services [Refer to Tag 234 10F NCAC .0703(a) Tuberculosis Test, Medical Examination & Immunizations]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure the 5, 10, or 15-hour medication aide training and the Medication Administration Skills Validation was completed for 3 of 3 sampled staff (Staff B, D, and E) [Refer to Tag G.S. 131D-4.5B (b) Adult Care Home Medication Aides; Training and	D912		

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D912	Continued From page 15 Competency Evaluation Requirements].	D912		
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: (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	D935		

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D935	Continued From page 16 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide 5, 10, or 15-hour medication aide training and the Medication Administration Skills Validation was completed for 3 of 3 sampled staff (Staff B, D, and E). The findings are: 1. Review of Staff B's personnel record revealed: -The hire date as a medication aide (MA) was documented as 06/19/19. -There was no documentation that Staff B had completed the 5, 10, or 15-hour MA training or completed a Medication Administration Skills Validation. -Staff B had passed the MA examination but a date was not provided on the verification documentation dated 06/13/19. Review of a resident's electronic Medication Administration Record (eMAR) from October 2019 revealed:	D935		

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D935	Continued From page 17 -Staff B had documented she had administered the residents medications on 10/23/19 and 10/24/19 4:00pm, 6:00pm, and 8:00pm. -Medications included pain medication, an anticoagulant, and 2 medications for anxiety. Review of another resident's eMAR from October 2019 revealed Staff B had documented she had administered insulin to the resident on 10/23/19 and 10/24/19 at 8:00pm. Interview with Staff B on 10/30/19 at 4:15pm revealed: -She worked as a MA and as a personal care aide (PCA). -She was scheduled to work as a second shift MA today (10/30/19). -She had not completed a 5, 10, or 15-hour MA training course or a Medication Administration Skills Validation prior to administering medications. -She had been orientated on the medication cart by another MA during her first week of hire. Refer to interview with the interim Health Care Coordinator (HCC) on 10/30/19 at 12:01pm. Refer to the interview with the Business Office Manager (BOM) on 10/30/19 at 3:55pm. Refer to interview with the interim Executive Director on 10/30/19 at 3:45pm. 2. Review of Staff D's personnel record revealed: -The hire date as a medication (MA) and as a personal care aide (PCA) was documented as 06/13/19. -There was no documentation Staff D had completed the 5, 10, or 15-hour MA training or a Medication Administration Skills Validation.	D935		

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D935	Continued From page 18 -Staff D had passed the written MA examination on 06/02/09. -Staff D did not have an employment verification form completed to show 24 months of employment as an MA prior to the hire date. Interview with Staff D on 10/30/19 at 2:55pm on revealed: -She worked as a medication aide (MA) and as a personal care aide (PCA). -She administered medications to the residents and would assist the PCAs on the floor with personal care. -The Health Care Coordinator (HCC) and another MA had watched her administer medications sometime after she was hired. -She remembered completing some training. -She could not remember if it was at the current facility or a previous facility where she had worked. Refer to interview with the interim Health Care Coordinator (HCC) on 10/30/19 at 12:01pm. Refer to the interview with the Business Office Manager (BOM) on 10/30/19 at 3:55pm. Refer to interview with the interim Executive Director on 10/30/19 at 3:45pm. 3. Review of Staff E's personnel record revealed: -The hire date as a medication aide (MA) was documented as of 07/24/19. -There was no documentation Staff E had completed the 5, 10, or 15-hour MA training or Medication Administration Skills Validation. -Staff E passed the written MA examination on 05/04/10. -Staff E did not have an employment verification from completed showing employment as an MA	D935		

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D935	Continued From page 19 for the 24 months prior to the hire date. Interview with Staff E on 10/30/19 at 8:40am and at 2:20pm revealed: -She worked as a MA and as a personal care aide (PCA). -She administered medications to the residents. -She assisted the PCAs with personal care on if they needed her. -She helped transport residents or take them to the bathroom. -She remembered the Health Care Coordinator (HCC) watched her complete a medication pass soon after she was hired. Observation during medication pass on 10/30/19 between 7:45am and 9:30am revealed Staff E was observed administering medications to residents on the second floor of the facility. Refer to interview with the interim Health Care Coordinator (HCC) on 10/30/19 at 12:01pm. Refer to the interview with the Business Office Manager (BOM) on 10/30/19 at 3:55pm. Refer to interview with the interim Executive Director on 10/30/19 at 3:45pm. Interview with the interim Health Care Coordinator (HCC) on 10/30/19 at 12:01pm revealed: -She did not know what training each staff member had completed. -She had not started helping with staff training. Interview with the Business Office Manager (BOM) on 10/30/19 at 3:55pm revealed: -She was responsible for filing and keeping a record of staff's hiring and training documents. -The HCC was responsible for completing the	D935		

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D935	Continued From page 20 medication aide (MA) 5, 10, or 15-hour training -The previous HCC's last day of work was 10/18/19. -She relied on the previous HCC to give her documentation that the clinical training had been completed for each staff. -She did not know what clinical training was required for MAs. -She had everything filed that the previous HCC had given her regarding training for the medication aides (MA). -She did not have a certificate for the completion of the training for the sampled staff so it "must not have been completed." -The previous HCC and the interim Executive Director (ED) were in the process of auditing the staff records to determine what training was missing. Interview with the interim Executive Director on 10/30/19 at 3:45pm revealed: -The facility had an entire room full of records and the training documentation could be in that room. -She did not have time to look for the training documentation among all the records. -The HCC and the BOM were responsible for making sure all the staff had completed all required training. -The HCC was responsible for completing the MA training, but the BOM was responsible for following up to make sure the required training was completed. -The BOM "should have known" what clinical training was required for each position and what staff members were missing any required training. The facility failed to ensure the 5, 10, or 15-hour medication aide training and Medication Administration Skills Validation were completed	D935		

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D935	Continued From page 21 for 3 of 3 sampled staff (Staff B, D, and E) prior to the staff administering medications to the residents increasing the risk for medication errors. This failure was detrimental to the health, safety and welfare, and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/30/19 for this violation. CORRECTION FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 14, 2019.	D935		