Received via electronic mail 01/09/23

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099018	A. BUILDING: _____ B. WING _____	R 12/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

(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 from 12/06/22 through 12/07/22.	{D 000}		
{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 observation, record review and interviews, the facility failed to ensure health care referral and follow up to meet the health care needs for 1 of 5 sampled residents (#3) who was receiving oxygen therapy without an order. The findings are: Review of Resident #3's current FL2 dated 01/11/22 revealed: -Diagnoses included hypertension, seizures, depression and leukopenia. -There was an order for oxygen 2 liters (L) to be administered via nasal cannula as needed (PRN) for shortness of breath). Review of Resident #3's physician's order dated 01/11/22 revealed: -There was an order request written by the Health and Wellness Director (HWD) dated 12/22/21 to discontinue the PRN oxygen order since it was last used in July 2021. -The primary care provider (PCP) signed the order to discontinue Resident #3's PRN oxygen on 01/11/22. Review of Resident #3's signed medication lists	{D 273}	D273 Collaborative Care Review of all residents to begin January 2023. This review will be a comprehensive review of current residents' treatment and medication orders, as well as skin assessments and medical diagnosis. Collaborative Care meetings will be held monthly. All staff trained on proper documentation and notification to supervisor to include residents' behaviors and residents' use of medical equipment – regardless of the presence of a current order. Additionally, staff were trained to notify supervisor of any medical equipment present in a resident room without orders from the PCP or medical provider. Training completed 12/29/2022. Concentrator was removed from the resident room on 12/07/2022.	

Reviewed and acknowledged 01/11/23. SG

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{D 273}	Continued From page 1 dated 04/12/22 and 09/27/22 revealed there was no order for oxygen. Review of Resident #3's licensed health professional support (LHPS) evaluations dated 08/15/22 and 11/07/22 revealed: -Resident #3's LHPS evaluations had oxygen administration and monitoring as a marked task. -The LHPS nurse documented the oxygen order was listed on the FL2 but not the current electronic medication administration record (eMAR). -The LHPS nurse recommended the facility either add the oxygen order to the eMAR for staff to document administration or have the PCP discontinue the order if indicated. -The LHPS evaluation dated 08/15/22 was signed by the facility's previous Resident Care Coordinator (RCC). -The LHPS evaluation dated 11/07/22 was signed by the facility's current HWD. Review of Resident #3's October, November and December 2022 eMARs revealed there were no entries for oxygen 2L PRN. Review of Resident #3's October, November and December 2022 electronic treatment administration record (eTAR) revealed there were no entries for oxygen 2L PRN. Review of Resident #3's progress notes revealed there were no documented notes regarding his use of oxygen from 09/11/22 through 12/06/22. *Observation of Resident #3's room on* 12/06/22 at 4:08pm revealed there was an oxygen concentrator with nasal cannula tubing next to his bed.	{D 273}		

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{D 273}	Continued From page 2 Interview with Resident #3 on 12/06/22 at 4:10pm revealed: -He thought his PCP ordered his oxygen to be worn at night. -He had been wearing his oxygen at 2L every night for over a year. -He felt short of breath at night if he was not wearing his oxygen. -He never felt short of breath during the day, so he did not wear it during the day, even if he took a nap. -None of the facility staff had said anything to him about using the oxygen at night. Interview with a medication aide (MA) on 12/07/22 at 8:07am revealed: -She worked day shift and Resident #3 was always up for the day by the time she arrived for work. -She thought Resident #3 had a PRN oxygen order that was recently discontinued due to non-use. -She had never seen Resident #3 wearing oxygen. -Resident #3 never appeared to be or complained of being short of breath. Telephone interview with a representative from the facility's contracted pharmacy on 12/07/22 at 10:15am revealed: -The pharmacy did not enter oxygen orders into the facility's eMAR system. -He was not able to see that Resident #3 had an order on file for oxygen. -If a resident was ordered oxygen, the facility would enter and remove that order from the eMAR. Telephone interview with Resident #3's PCP on 12/07/22 at 12:00pm revealed:	{D 273}		

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{D 273}	Continued From page 3 -She was not able to determine if Resident #3 had a current order for oxygen or not. -Resident #3 did not have any respiratory diagnoses, so there would be no harm to Resident #3 using oxygen, but he did not need it. -She had assessed Resident #3 the day prior, on 12/06/22, and his oxygen saturation was 99% on room air right after he ambulated (walked), which was good. -Resident #3 had never talked with her about having shortness of breath or mentioned to her that he had been using oxygen at night. -She would expect the facility to contact her if Resident #3 was using oxygen so that she could write an order for it. -The facility had not contacted her in the previous three months regarding Resident #3 using oxygen. Interview with the HWD on 12/07/22 at 1:00pm revealed: -Resident #3 did not have a current order for oxygen. -She was not aware that Resident #3 was using oxygen at night. -Resident #3 had an oxygen concentrator in his room at least since June 2022, but she had not been familiar with his oxygen order so did not question it. -She signed Resident #3's LHPS evaluation from 11/07/22, but did not notice the recommendation to follow up with his PCP regarding the oxygen order. -She had not completed audits of residents' records in the last few months due to being busy training new staff. Interview with a second MA on 12/07/22 at 1:40pm revealed: -Resident #3 previously had an order for the	{D 273}		

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{D 273}	Continued From page 4 oxygen, but when the order was discontinued in January 2022, he became upset when staff attempted to remove the oxygen concentrator from his room. -Resident #3 told staff the oxygen concentrator belonged to him, and he could use it if he wanted to, so they left it in his room. -She knew that Resident #3 occasionally used oxygen at night, but had not told the HWD. -She did not document Resident #3's use of oxygen because she had not thought to do so. Interview with a personal care aide (PCA) on 12/07/22 at 4:30pm revealed: -He primarily worked day shift, but in the last six months he had worked a couple night shifts and saw Resident #3 wearing oxygen. -Resident #3 was independent with most of his care and applied the oxygen by himself. -The PCAs did not document the oxygen use, and he did not know if the MAs documented it. Interview with the Executive Vice President of Operations on 12/07/22 at 3:30pm revealed: -If a resident was using oxygen without an order, the MA would be responsible for notifying the RCC or HWD. -Once the HWD was notified, she would be responsible for following up with the PCP regarding the need for an order or evaluation. -As far as she knew, nobody had notified the HWD that Resident #3 was using oxygen without having an order for it.	{D 273}		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the	{D 358}		

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{D 358}	Continued From page 5 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: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 5 residents (#5) related to an anti-anxiety medication. The findings are: Review of Resident #5's current FL2 dated 05/26/22 revealed an order for lorazepam 0.5mg 1 tablet every morning. Review of Resident #5's physician's orders dated 06/02/22 revealed an order for lorazepam 0.5mg 1 tablet every day at 2:00pm. Review of Resident #5's physician's orders dated 08/11/22 revealed an order for lorazepam 0.5mg 3 times daily. Review of Resident #5's electronic Medication Administration Records (eMARs) for November 2022 revealed: -There was an entry for lorazepam 0.5mg 1 tablet 3 times daily scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -There was no documentation lorazepam was administered for 29 of 90 opportunities on 11/20/22 through 11/28/22 at 8:00am, from 11/19/22 through 11/28/22 at 2:00pm, and from	{D 358}	D358 The facility will ensure that the preparation and administration of medication, prescription and non-prescription, and treatments by staff are in accordance with; 1) orders by a licensed prescribing practitioner, maintained in the resident's record; 2) rules in this section and the facility's policies and procedures.	

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{D 358}	Continued From page 6 11/19/22 through 11/28/22 at 8:00pm. Observation of Resident #5's medications available for administration on 12/07/22 at 10:17am revealed lorazepam 0.5mg 1 tablet 3 times daily was dispensed to the facility on 11/28/22 with a quantity of 75 tablets and 65 tablets were remaining. Interview with a pharmacy technician at the facility's contracted pharmacy on 12/07/22 at 9:31am revealed: -Resident #5 had an order for lorazepam 0.5mg 1 tablet 3 times daily. -Lorazepam was dispensed to the facility on 10/21/22 with a quantity of 36 tablets. -Lorazepam was dispensed to the facility on 11/12/22 with a quantity of 15 tablets and on 11/28/22 with a quantity of 75 tablets. -On 11/09/22, the facility requested a refill of Resident #5's lorazepam, but there were no refills on the medication. -The pharmacy faxed Resident #5's previous mental health provider (MHP) indicating Resident #5 needed a new prescription for a refill. -There was no response from Resident #5's previous mental health provider (MHP). -On 11/12/22, the pharmacy authorized a 5-day supply of lorazepam. -The pharmacy received a new prescription for lorazepam 0.5mg 1 tablet 3 times daily on 11/28/22. Interview with a medication aide (MA) on 12/07/22 at 10:32am revealed: -Resident #5 was out of lorazepam for about 10 days in November 2022 due to his switching to a new MHP. -The new MHP came to the facility at the end of November 2022 and wrote a new prescription for	{D 358}	Prior to the follow-up survey conducted 12/6/22 through 12/7/22, an internal monitoring audit was conducted by the administrator on 12/2/22. Based on review of Resident #1 and #2 of audit, it was discovered that the facility had failed to administer medication to these residents as ordered by their practicing physician as resident #5 indicated in summary statement of deficiencies on follow-up survey. Medication errors have been completed on all three residents and signed by their physician. A plan of correction was implemented by the facility to correct and ensure that all residents have all their medication readily available as needed. The plan of correction implemented a medication error practice and procedure on 12/2/22. This	

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{D 358}	Continued From page 7 lorazepam. -Resident #5 was very irritable during the time when he was out of lorazepam. -MAs tried to reorder Resident #5's lorazepam when it was down to the last bubble card. -MAs faxed the requests for medication refills and told the Resident Care Coordinator (RCC). -She faxed a request to Resident #5's previous MHP to refill Resident #5's lorazepam (She could not remember the date.), but she did not follow up with the MHP's office when the order was not received. -She told the RCC she had not received the order for Resident #5's lorazepam, but could not remember when. Telephone interview with the floating MHP with the facility's contracted MHP's office on 12/07/22 at 10:56am revealed: -He was recently employed by the facility's contracted MHP. -Resident #5's previous MHP left the last week of October 2022. -He received a message from the facility requesting a refill of Resident #5's lorazepam on 11/28/22. -He saw Resident #5 and wrote a prescription for a 60-day supply of lorazepam 0.5mg 1 tablet 3 times daily on 11/28/22. -He did not see any documentation of the facility calling the MHP's office prior to 11/28/22 to request a refill of lorazepam. -The facility could have called in to the triage line and requested a 3-day courtesy supply of lorazepam for Resident #5. -He thought the facility could have kept calling into the triage line request lorazepam until Resident #5 was assigned a new MHP provider. Interview with the Health and Wellness Director	{D 358}	procedure includes a control count sheet form for each resident on prescription medication to ensure that the medication is reordered and, in the facility, when needed. An In-Service training was conducted with staff on 12/2/22 on these practices and procedures. Training material and new control count form were in place on 12/2/22. Resident Care Coordinator/and or designee to review Quick Mar Exception report daily for errors or missed medications along with controlled count forms. Provide update to Operational Manager/and or designee weekly. Operational Manager/and or designee to provide a written report to Administrator/and or designee monthly of all missed medication and reasons for why it was not administered. Completion Date: 12/2/22 and 12/27/22	

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{D 358}	Continued From page 8 (HWD) on 12/07/22 at 12:55pm revealed: -Resident #5's previous MHP no longer provided services at the facility. -The previous MHP gave a week's notice that she was leaving, and she thought the MHP's office would have another MHP available for residents at the facility. -She did not request a refill of Resident #5's lorazepam when the facility found out the previous MHP would no longer provide services. -When staff tried to send a message to request a refill of Resident #5's lorazepam, the message went to the previous MHP provider's inbox. -She was responsible for ensuring medications were available for Resident #5. -Staff sent messages to the previous MHP to request a refill of lorazepam, but she had not called into triage to speak to a live person to request a refill. -She attempted to speak to a live person in triage, because she did not know the facility's code which was requested via the automated phone system when the facility dialed in. -She was not aware of any increased anxiety or changes in Resident #5's behaviors during the time his lorazepam was not available in the facility. -She placed a call to the pharmacy in November 2022 and found out Resident #5 needed a new prescription in order to refill lorazepam, but she did not follow up with the pharmacy after the initial contact. Interview with the RCC on 12/07/22 at 1:25pm revealed: -Resident #5 was out of his medication for a while in November 2022. -She tried to contact the previous MHP via email, but received a response saying the previous MHP was no longer with the facility's contracted MHP's	{D 358}		

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{D 358}	Continued From page 9 office -She tried to email someone else at the MHP's office, but she was unsuccessful. -She went to the HWD who gave her a phone number to call to request a refill, but the automated phone system kept asking for a facility code and she did not know it. -She went back to the HWD to explain what was going on and she did not do anything else to follow up. -There was a new prescription written for lorazepam at the end of November 2022. -Resident #5 was a little more agitated and "snappy" around the third day he was out of his medication. Second telephone interview with the floating MHP with the facility's contracted MHP's office on 12/07/22 at 2:01pm revealed: -Lorazepam was prescribed for Resident #5 for anxiety. -Lorazepam was a medication that needed to be weaned off. -When lorazepam was stopped suddenly and not weaned, Resident #5 could have experienced increased anxiety and withdrawal symptoms including hallucinations, tremors, and other alcohol-like withdrawal symptoms. Interview with the facility's Executive Vice President of Operations on 12/07/22 at 3:15pm revealed: -The facility was in between MHPs when Resident #5 ran out of lorazepam. -She expected the MAs or the HWD to continue to contact the MHP until they got a response regarding Resident #5's lorazepam. -Staff should have reached out to Resident #5's PCP if they could not get in contact with the MHP.	{D 358}		

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{D 358}	Continued From page 10 Based on observations, record reviews, and interviews, it was determined Resident #5 was not interviewable. Attempted contact with Resident #5's guardian on 12/07/22 at 2:45pm was unsuccessful. The facility failed to ensure medications were administered as ordered for Resident #5 who was not administered 29 doses of his anti-anxiety medication over a 10-day period which resulted in reports by staff of increased anxiety and could have resulted in alcohol-like withdrawal symptoms including hallucinations and tremors. This failure was detrimental to the health, safety, and welfare of the resident which constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on December 7, 2022 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED February 15, 2022.	{D 358}		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by:	D 371	D371 The facility will ensure that medications are administered in accordance with infection control measures to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for residents and staff.	

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D 371	Continued From page 11 Based on observations and interviews, the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA), who performed a fingerstick blood sugar (FSBS) and insulin injection with no gloves; and failed to wash or sanitize her hands before and after a FSBS check and insulin administration. The findings are: Review of the facility's Infection Prevention and Control Program Policy dated 10/23/20 revealed: -Healthcare personnel should use an alcohol-based hand rub or wash with soap and water immediately before touching a patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. -Gloves should be worn when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, or potentially contaminated intact skin could occur. -Staff were to wear gloves during blood glucose monitoring, insulin administration, and during any other procedure that involved potential exposure to blood or body fluids. Observation of medication administration to a resident during the tour of the facility on 12/06/22 at 9:31am revealed: -The medication aide (MA) walked into a resident's room with insulin pens, a lancet, and glucose strips while not wearing gloves. -The MA left the resident's room and came back, ungloved, with alcohol wipes. -The MA left the resident's room again and came back, ungloved, with the resident's glucometer. -There was no hand sanitizer in the resident's	D 371	The facility shall adhere to the Infection Control Policy dated 10/23/20. All community staff were re-trained on the facility's Infection Prevention and Control Program Policy by an RN Instructor provided through Southern Pharmacy on 12/14/22. The objective of this training was to establish basic infection prevention principles, discuss infection prevention measures, and demonstrate correct practices and prevention measures involving bloodborne pathogens. Training curriculum and attendance provided. Resident Care Coordinator/and or designee to observe random medication passes with each med aide monthly to ensure that proper infection control procedures are being followed. Evaluations to be reviewed by Administrator/and/or Administrator Designee. Infection Prevention and Control training to be completed annually. Completion date: 12/14/22	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATRIOT LIVING OF YADKINVILLE	409 HARRISON AVENUE YADKINVILLE, NC 27055

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D 371	Continued From page 12	D 371		

room and no faucet for hand washing.
-The MA cleaned the residents right second finger with the alcohol wipe and laid it on the resident's pillow.
-The MA pricked the finger with the lancet and placed a drop of blood on the glucose strip.
-The MA picked the alcohol wipe up from the resident's pillow and placed in on the finger that had been pricked.
-The FSBS reading was 223.
-The MA retrieved the resident's insulin supplies and returned to the medication room down the hall where she disposed of the resident's used diabetic supplies and placed the resident's glucometer and insulin back in the medication cart.
-The MA sat down at a desk in the medication room and did not sanitize or wash her hands.
-The MA did not don gloves while obtaining the FSBS or administration of insulin to the resident or wash or sanitize her hands as stated in the facility's policy.

Interview with the MA on 12/06/22 at 9:36am revealed:
-Prior to FSBS checks and insulin administration, she sanitized the resident's finger with a alcohol pad.
-She sanitized and washed her hands prior to and after FSBS checks and insulin administration, but she had not sanitized her hands yet after insulin administration to the resident at 9:31am on 12/06/22.
-She sanitized her hands before going into the resident's room the first time on 12/06/22, but she had not sanitized her hands the two other times she left the resident's room prior to checking the FSBS and administering insulin to the resident.
-She did not wear gloves because she was allergic to gloves and when she put the gloves on,

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D 371	Continued From page 13 they cut her hands. -She had not told anyone she was allergic to gloves. -She had infection control training a few months ago. Observation of the gloves available in the facility for staff use revealed the facility had a supply of vinyl, powder free gloves. Interview with another medication aide (MA) on 12/07/22 at 10:32am revealed: -She wore gloves to prevent cross contamination during insulin administration. -She put her gloves on first and got everything ready prior to checking the resident's fingerstick blood sugars (FSBS) and insulin administration. -After insulin administration, she removed her gloves and sanitized her hands. -All staff were required to wear gloves during FSBS checks and insulin administration. Interview with the Health and Wellness Director (HWD) on 12/07/22 at 12:55pm revealed: -During FSBS checks and insulin administration, MAs were expected to wash their hands, put gloves on, get the resident's diabetic supplies ready, scrub the resident's finger, collect blood for a FSBS reading, administer insulin if needed, dispose of wastes properly, take off the gloves, and wash their hands. -No MAs had informed her that they had allergies or could not wear gloves. -All MAs were expected to sanitize their hands and wear gloves when they check FSBSs and administer insulin. Interview with the facility's Regional Director on 12/07/22 at 3:15pm revealed: -All MAs were expected to wear gloves for FSBS	D 371		

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D 371	Continued From page 14 checks and insulin administration. -The MA who administered insulin on the morning of 12/06/22 did not communicate that she had any allergies to the facility's gloves. -There should not have been any problems with the MAs wearing gloves because the gloves available in the facility for staff use were latex free.	D 371	D935 The facility will ensure that all staff hired to administer medication will complete the training, competency evaluation, and testing required to pass medication in accordance with state rules and regulations. A staff training log has been developed to assist the facility in assuring that all training and testing is completed with all medication aides. Resident Care Coordinator/and or designee must report to Operational Manager/and or designee all new employees that are training to become Medication Aide, including dates of training, date of testing, and result of test. Operational Manager/and or designee to report findings above to administrator/or administrator designee monthly. Administrator/or designee to review at random Medication Aide training and testing every six months. Completion Date: 12/27/22.	
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	D935		

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D935	Continued From page 15 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 interviews and record review, the facility failed to ensure 1 of 3 sampled staff (Staff C) who administered medications met the requirements related to employment verification as a medication aide or completion of the 5, 10 or 15 hours of medication aide training prior to passing medications, and completion of a written medication aide examination within 60 days of hire. The findings are: Review of Staff C's personnel record revealed: -Staff C was hired as a medication aide (MA) and personal care aide (PCA) on 07/29/22. -She completed the 5- and 10-hour medication aide training courses on 08/02/22. -She completed the Medication Administration Clinical Skills Competency Validation checklist on 08/02/22 and again on 11/02/22. -There was no documentation Staff C passed the state approved written medication aide test within 60 days of hire. Observation of the morning medication pass on	D935		

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D935	Continued From page 16 12/06/22 at 9:31am revealed Staff C was assigned to a medication cart and was observed passing medication to a resident. Review of a resident's July, August, September, October, November and December 2022 electronic medication administration records (eMAR) revealed: -On 07/31/22, Staff C documented administering medication. -From 08/01/22 through 08/31/22 there were 10 days Staff C documented administering medication. -From 09/01/22 through 09/30/22 there were 10 days Staff C documented administering medication. -From 10/01/22 through 10/31/22 there were 9 days Staff C documented administering medication. -From 11/01/22 through 11/30/22 there were 10 days Staff C documented administering medication. -From 12/01/22 through 12/06/22 there were 3 days Staff C documented administering medication. Telephone interview with Staff C on 12/07/22 at 4:20pm revealed: -She was hired at the facility as a MA on 07/29/22. -She completed the 5 and 10 hours of MA training at the beginning of August 2022. -She had never completed the written MA test due to conflicts with scheduling the test in October 2022. -She was scheduled to take the state approved written MA test on 01/25/23. -She had started administering medication at the end of July 2022, while she was training with the facility's previous Resident Care Coordinator	D935		

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D935	Continued From page 17 (RCC). -She began administering medication on her own, without another staff present for training, in August 2022 after she completed her MA Clinical Skills Competency Validation checklist. Interview with the Health and Wellness Director (HWD) on 12/07/22 at 3:50pm revealed: -Staff C was recently married and was unable to schedule her MA test in October 2022 because the names on her license and social security card did not match. -Staff C redid the Medication Administration Clinical Skills Competency Validation checklist on 11/02/22 to extend the date when her MA test would be due. -The Business Office Manager (BOM) was responsible for ensuring personnel records were current and complete with either the MA employment verification or completion of the 5 and 10 or 15 hour training prior to staff being added to the schedule to work. -She would have been responsible for ensuring Staff C took her MA written test within the proper time frame or removed Staff C from the medication cart until she passed the test. -She thought that since Staff C redid the MA Clinical Skills Competency Validation checklist, she still had time before the MA written test was due. -Staff C should not have been documenting medication administration on 07/31/22, because MAs were not supposed to receive a profile in the eMAR system until they completed their training. -The facility's previous RCC had created Staff C's profile in the eMAR system which allowed her to document administering medication. Telephone interview with Staff C on 12/07/22 at 4:20pm revealed:	D935		

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D935	Continued From page 18 -She was hired at the facility as a MA on 07/29/22. -She completed the 5 and 10 hour MA training at the beginning of August 2022. -She had never completed the written MA test due to conflicts with scheduling the test in October 2022. -She was scheduled to take the state approved written MA test on 01/25/23. -She had started administering medications at the end of July 2022 while she was training with the facility's previous RCC. -She began administering medications on her own, without another staff present for training, in August 2022 after she completed her MA Clinical Skills Competency Validation checklist. Attempted telephone interview with the BOM on 12/07/22 at 4:08 was unsuccessful.	D935		