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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
	HAL034013	A. BUILDING: _____ B. WING _____	09/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHULER HEATH CARE/STOREY VILLA	260 PITT STREET KERNERSVILLE, NC 27284

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on September 5-6, 2018 with an exit via telephone on September 7, 2018.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with 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, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 2 staff sampled (B) was tested for tuberculosis (TB) disease upon hire. The findings are: Review of Staff B, medication aide/supervisor's personnel record revealed: -Staff B was hired on 09/28/16. -Staff B had a tuberculosis (TB) skin test placed on 10/12/16 and read as negative on 10/15/16. -Staff B had a TB skin test placed on 01/03/18 and read as negative on 01/05/18. -There was no documentation of any TB skin tests for Staff B after 10/15/16 and prior to 10/03/18 date. Telephone interview with the Co-Administrator,	D 131	Administrators have now began having on-site nurses administer T.B test at the facility rather than relying on staff to obtain at an off-site facility. This prevents a delay in getting test given and read. Co-Administrators will have nurse give test as close to a month apart as suggested, as possible in the future.	10-12-18

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Kimberly L Wheeler - administrator — 10-8-18

STATE FORM 6899 LE8811 If continuation sheet 1 of 20

Reviewed and Accepted with addendum on page 14
HCP
10-19-2018

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D 131	Continued From page 1 Staff C, on 09/07/18 at 9:15 am revealed: -The facility had Co-Administrators (Staff C and Staff D). -Staff D, Co-Administrator was responsible to assure TB skin tests were done for new staff hired. -The TB skin test information was kept on file in the corporate office. -Staff B was identified during a routine audit of personnel records in January 2018 for compliance with TB requirements. -Since there was no documentation for a second TB skin test within 12 months, Staff B received another TB skin test. -The Co-Administrators did not know Staff B needed the second TB test prior to the routine audit. Telephone interview on 09/07/18 at 1:38 pm with Staff B revealed: -The Co-Administrators were responsible for the requirements at hire for employees. -She was hired as a medication aide (MA) in September 2018. -She had a TB skin test placed and read shortly after she came to work at the facility. -She had another TB skin test placed and read in January 2018. -The Administrators told her, in January, that there was documentation for a second TB test placed in 2016 or 2017. -She received another TB test in January 2018.	D 131		
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	D 310		

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D 310	Continued From page 2 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 ensure 1 of 1 resident (#1) with physician's orders for a therapeutic diet pureed therapeutic diet was served as ordered. The findings are: Review of Resident #1's current FL2 dated 07/02/18 revealed: -Diagnoses included dysphagia, past aspiration pneumonia, and type 2 diabetes mellitus. -There was a physician's order for a pureed diet with nectar thick liquids. Review of the therapeutic diet list posted in the kitchen revealed Resident #1 was to be served a pureed diet with nectar thick liquids. Review of the therapeutic diet menus revealed there was no pureed diet menu for breakfast, lunch or dinner. Review of the regular lunch menu for 09/05/18 revealed residents were to be served 1 cup of blackeyed peas with ham, one-half cup of turnip greens, one-half cup of corn/okra/tomatoes, 1 slice of cornbread, one-half cup of applesauce, and tea/lemonade/water. Observation of the regular lunch meal service on 09/05/18 from 12:30 pm to 1:00 pm revealed:	D 310		

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D 310	Continued From page 3 -Resident #1 was served 1 cup of blackeyed peas, a 4 inch round slice of baked ham, one-half cup of turnip greens, one-half cup of corn/okra/tomatoes, 1 slice of cornbread, one-half cup of applesauce, nectar thick tea, and nectar thick water. (None of the food items were pureed). -Resident #1 ate 90% of the corn/okra/tomatoes, none of the cornbread, 25% of the turnip greens, 50% of the blackeyed peas, 2 pieces of ham (1 by 1¼ inch pieces) were consumed, 100% of the applesauce, and 50% of the tea and water. -Resident #1 cleared his throat 2 times and coughed 1 time while slowly eating the ham. Resident #1 did not become choked or strangled. It could not be determined if Resident #1 was served the appropriate meal due to no pureed therapeutic diet menu available for the lunch meal for staff guidance. Interview on 09/05/18 at 12:55 pm with the medication aide/Supervisor (MA/S) revealed: -She knew Resident #1 was ordered a pureed diet on his FL2. -The facility did not offer pureed diets as a choice of therapeutic diets. -The resident had told her he would not eat a pureed diet. -Resident #1 was instructed to chew food 26 times before swallowing by the speech therapist. -Resident #1 had speech therapy visits two times a week. -The speech therapist told her the resident should be receiving a pureed diet, but that was not possible at the facility because she did not have any equipment to puree food. The speech therapist had recommended at least chopped meats in her recent conversations with the MA/S. -The Co-Administrators told her Resident #1	D 310		

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D 310	-Continued From page 4 would have to be served regular texture food because the facility did not offer pureed diets. -She tried to prepare Resident #1's food by cooking it extra to soften the food. Sometimes, she would chop the meats as fine as possible. -Resident #1 was able to cut his food into small pieces to help with his swallowing. Interview on 09/05/18 at 1:00 pm with Resident #1 revealed: -He had a stroke earlier in the year and had to go to a local rehabilitation facility before he came to the facility in July 2018. -The MA/S did a good job preparing his food so he could eat it. -He understood the facility did not prepare pureed food. -He purchased his own thickened liquids and foods that were soft to supplement any meal that had food he did not like or could not eat. -He also had nutritional supplements he purchased for regular consumption. -He had a speech therapist coming to the facility 2 times a week to help with improving his swallowing and providing techniques to help him get back to a normal diet. -He avoided foods that might make him choke like corn, dry cornbread and salads. -He had not gotten choked while consuming the present diet. -He was supposed to chew his food 26 times before swallowing by instruction from the speech therapist. Interview on 09/05/18 at 3:55 pm with Resident #1's Power of Attorney (POA)/ family member revealed: -She knew the resident needed thickened liquids	D 310		

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D 310	Continued From page 5 because she and the resident purchased pre-thickened (nectar thick) tea, water, and juices on a regular basis. -The MA/S talked to her regarding making Resident #1's food as soft as possible and providing alternatives when the menu called for meats that were too tough for the resident to chew and swallow. -Resident #1 had a speech therapist coming to the facility 2 times a week to help the resident learn techniques to switch to a regular diet. -Resident #1 also had supplemental shakes, puddings, and yogurts, apple sauce and snacks he liked and could eat with any problem with swallowing. -The facility's Co-Administrators had not told her the facility did not offer pureed diets and she did not know if the gastroenterologist had changed the diet order from pureed. -When Resident #1 visited the POA's home, she used a blender to puree his food. Interview on 09/06/18 at 10:15 am with the speech therapist revealed: -She visited Resident #1 at the facility 2 times a week. -Resident #1 had a pureed diet ordered when she started seeing the resident. -She had instructed the resident that he was able to handle mechanically chopped meats and soft vegetables on her most recent visits. -She instructed the resident to chew his food 20 plus times before swallowing. Telephone interview on 09/06/18 at 2:50 pm with the Nurse Practitioner (NP) at Resident #1's primary care provider's office revealed: -There was documentation Resident #1 was seen by the NP for a wellness check in April 2018 and a new FL2 was signed in July 2018.	D 310		

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D 310	Continued From page 6 -Resident #1's digestive health physician should be ordering the diet. -The last information the NP's office had was for a pureed diet. Telephone interview on 09/07/18 at 10:18 am with Resident #1's digestive health physician's office nurse revealed: -The last documentation for Resident #1's diet was in June 2018 and mechanical soft was the diet ordered. -The was no documentation for notes from speech therapy regarding Resident #1's suggested diet from June 2018 to present. -The nurse stated the primary care physician shoiud not be ordering the diet for Resident #1; the digestive health physician or physician's assistant should be ordering Resident #1's diet. Interview on 09/06/18 at 6:10 pm with Co-Administrator (Staff C) revealed: -The facility did not offer pureed diets for residents and that was the reason why no therapeutic diet menu was available for pureed diets. -Resident #1 had been working with speech therapy to be able to remain at the facility by getting back to a regular diet. -The diet order for pureed diet should not have been on the FL2. -The facility had obtained an order from Resident #1's primary care NP to discontinue the puree diet and start chopped meat today (09/06/18). -The MA/S would be instructed to chop Resident #1's meats.	D 310	All new residents and their doctors will be made aware that the facility does not offer a pureed diet. FL2's will be reviewed by a Resident Care Manager when signed to assure correct diet is listed 10-1-18	
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 7 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 observations, interviews, and record reviews, the facility failed to assure medications were administered as ordered for 2 of 4 residents (Residents #1 and #3) observed during a medication pass on 09/05/18 including errors with torsemide (#1), potassium chloride (#1), and lactulose (#3). The findings are: The medication error rate was 12 % as evidenced by 3 errors of 25 opportunities observed during the 8:00 am medication pass on 09/05/18. 1. Review of Resident #1's current FL2 dated 07/02/18 revealed diagnoses included depression, essential hypertension, paroxysmal atrial fibrillation, and prolonged Q-T interval on electrocardiography. a. Review of Resident #1's current FL2 dated 07/02/18 revealed an order for torsemide 20 mg (used to treat excess fluid) one tablet daily. Observation on 09/05/18 at 8:35 am revealed: -The medication aide (MA) prepared and administered 5 oral medications to Resident #1.	D 358		

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D 358	Continued From page 8 -The MA used Resident #1's medication bottles, without referring to the medication administration record (MAR) to prepare the resident's 8:00 am medications. -Torsemide 20 mg was not included in the medications administered at 8:35 am. -The MA documented administration of 6 medications (including torsemide 20 mg) on the resident's MAR before moving to the next resident. Review of Resident #1's September 2018 MAR revealed torsemide 20 mg one tablet daily was preprinted on the MAR and scheduled for administration at 8:00 am daily, with documented administration at 8:00 am daily from 09/01/18 through 09/05/18. Observation of medication on hand for administration on 09/05/18 at 9:30 am revealed a container of torsemide 20 mg dispensed on 08/21/18 for 30 tablets with 24 tablets remaining. Interview on 09/05/18 at 10:15 am with the MA revealed: -She routinely administered medications according to the MAR. -Today, she prepared Resident #1's medications for administration using the medication bottles without referring to the MAR. -She overlooked Resident #1's bottle containing torsemide 20 mg when she prepared the medications. -She went down the list and documented Resident #1's medications on the MAR, but did not realize she had not prepared torsemide 20 mg for administration. Interview on 09/05/18 at 1:00 pm with Resident #1 revealed:	D 358	Additional medication training was done with this MA. The process of checking MAR and documenting med pass 1 pill at a time was reviewed to prevent errors. Resident care manager will do random observations of med passes to assure this policy is being followed 9-7-18	

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D 358	Continued From page 9 -He took his medications as prepared by the MA. -He did not always count or check the number of medications administered. Interview on 09/06/18 at 10:00 am with the Co-Administrator (Staff C) revealed: -The MA should look at the MAR for preparing residents' medications. -The MA told her she was very nervous when being observed for the medication pass (on 09/05/18) and overlooked preparing Resident #1's torsemide 20 mg. -She hurriedly documented administration on the resident September MAR and again overlooked the torsemide not being administered. b. Review of Resident #1's current FL2 dated 07/02/18 revealed an order for potassium 20 milliequivalents (meq) 2 tablets (40 meq) two times a day. (Potassium chloride is supplement used to treat low potassium.) Observation on 09/05/18 at 8:35 am revealed: -The medication aide (MA) prepared and administered 5 oral medications to Resident #1. -Potassium 20 meq 2 tablets (40 meq) was included in the medications administered at 8:35 am and each tablet was broken along the manufacturer's scored line into 2 pieces. -The MA handed Resident #1 the medications in a paper soufflé cup while he was sitting at the dining room table. -Resident #1 produced a small pair of channel lock pliers from his pocket and proceeded to mash the potassium chloride half tablets between the pliers making the pieces flat. -The resident added the flattened potassium chloride tablets to the top of a small amount of honey thick pre-thickened apple juice and spooned the medication into his mouth.	D 358	9-7-18 Staff has been reminded that a doctor's order must be obtained to crush a medication. Facility has also obtained a list of medications that should not be crushed from our Pharmacy. This Resident #1's Doctor changed ~~the~~ Potassium 20 meq order to a capsule that can to opened and sprinkled on his food.	

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D 358	Continued From page 10 -The MA documented administration of 6 medications (including 2 potassium 20 meq tablets) on the resident's MAR before moving to the next resident. Review of Resident #1's September 2018 MAR revealed potassium 20 meq 2 tablets (40 meq) two times a day [DO NOT CRUSH] was preprinted on the MAR with scheduled times for administration at 8:00 am daily and 8:00 pm daily and documented administration at 8:00 am on 09/05/18. Observation of medication on hand for administration on 09/05/18 at 9:30 am revealed a partial container of potassium 20 meq 2 tablets (40 meq) two times a day with [DO NOT CRUSH] printed on the label. Interview on 09/05/18 at 8:45 am with the MA revealed: -She prepared Resident #1's medications and broke the potassium chloride tablet in half along the score on the tablet. -Resident #1 had to be careful swallowing his food, and liquids and complained about the size of the potassium chloride tablets. -Resident #1 preferred to take the medications on his own by placing in applesauce or pre-thickened juice. -She placed the half tablets in the soufflé cup along with the resident's other medications on the table for Resident #1. -She routinely observed the resident take his medications before walking away. -Resident #1 had been using his personal tool to mash the potassium chloride tablets so as to make the pieces even smaller. -She did not stop Resident #1 from mashing or crushing the potassium chloride tablets because	D 358		

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D 358	Continued From page 11 he did it on his own. -She had not talked to administration or Resident #1's physician ot the contract pharmacy about Resident #1 crushing medication that should not be crushed. Interview on 09/05/18 at 8:40 am with Resident #1 revealed: -He took his medications as prepared by the MA. -He did not like to take the large tablets (potassium chloride 20 meq broken in half) without making them smaller, so he had his tool to mash the tablets. -He added the tablets on top of applesauce or his thickened juice to help with swallowing. -He did not have trouble taking his medication like that. Interview on 09/05/18 at 10:00 am with the Co-Administrator (Staff D) revealed: -The MA should not be crushing medications that cannot be crushed. -The MA should let the administration know if a resident was unable to take their medications. -The MA could also contact the prescribing physician if a resident needed their medication dosage form changed. -She would contact Resident #1's physician for changing the potassium chloride to a form of medication easier for the resident to swallow. 2. Review of Resident #3's current FL2 dated 05/18/18 revealed diagnoses included dyslipidemia, schizoaffective disorder, and chronic constipation. Review of Resident #3's physician orders dated 04/10/18, 05/11/18 and order on FL2 dated 05/18/18 revealed orders for Lactulose 10gm/15 ml give 30 ml (20gm) 3 times a day. (Lactulose is	D 358		

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D 358	Continued From page 12 used to treat constipation). Observation on 09/05/18 at 8:28 am of the 8:00 am medication pass revealed: -The medication aide (MA) prepared medications for Resident #1 including 6 solid dose oral medications, one powder form of medication, and one liquid medication (lactulose 10 gm/15ml). -The MA used a 30 ml plastic measuring cup to administer 20 mls (13.4 gms) and should have administered 30 ml (20 gm) of Resident #3's lactulose. Resident #3 consumed the 20 ml (13.4 gm) dose. -The MA administered the remaining 6 solid dose oral medications and the powder form of medication. Review of Resident #3's September 2018 medication administration record (MAR) revealed: -Lactulose 10 gm/15 ml give 30 mls (20gm) 3 times a day was pre-printed on the MAR and scheduled for 8:00 am, 2:00 pm, and 8:00 pm daily. -Lactulose 30 mls (20 gm) was documented as administered at 8:00 am on 09/05/18. Interview on 09/05/18 at 5:10 pm with the MA revealed: -She routinely administered 30 ml of Resident #1's lactulose 10mg/15ml when she worked. -She did not know she had administered 20 ml of Resident #3's lactulose instead of 30 ml. -She was nervous during the medication pass and must have misread the 20 gm dose for 20 ml. -She gave 30 ml at the 2:00 pm dose later in the day. Interview on 09/06/18 at 6:00 pm with the Co-Administrator (Staff C) revealed:	D 358	During the additional training dose, liquid measurements were reviewed and will be checked during random observations of med passes done by Resident Care manager.	9-7-18

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	HAL034013	A. BUILDING: ______ B. WING ______	09/07/2018

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D 358	Continued From page 13 -The MA had told her she was very nervous during the medication pass on 09/05/18. -The MA should have read the MAR for the amount (30 mls) of lactulose to administer to Resident #3. -She would instruct the MA to read all orders when preparing, and before documenting administration to assure what was administered was what was ordered. Interview on 09/06/18 at 6:30 pm with Resident #3 revealed: -He did not look at the amount of lactulose in the measuring cup before he took the medication. -He routinely received lactulose unless he was having loose stools; then he would refuse the medication. -He had 2 stools today, so the medication must be working fine.	D 358		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5	D934	[redacted] Nurse well provide on-site ~~OSHA~~ STATE approved class yearly. All new staff will complete on-line class upon hire to provide some training until Nurse is able to do on-site class.	9-20-18

Evidence [illegible] c̄ Administrator via phone 10-17-18 [illegible]

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D934	Continued From page 14 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 2 of 2 staff sampled (Staff A and B) who had been working for a least a year as Medication Aides (MA) received the annual state approved infection control training. The findings are: 1. Review of Staff A, MA's personnel records revealed: •Staff A was hired in March 2017. •There was documentation for completing 3 hours of "Blood Borne Pathogen" training dated 12/27/17. -There was no documentation for completion of the annual state approved infection control training. Interview on 09/06/18 at 5:30 pm with Staff A revealed: -She had taken an online "Blood Borne Pathogen" training in December 2017. -She had not taken the annual state approved infection control training in 2017 or 2018. -The Co-Administrators had informed her that she could take the 3 hours online on the web for her infection control training requirement. Refer to the interview with the Administrator on 09/07/18 at 9:10 am.	D934		

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D934	Continued From page 16 Refer to the telephone interview on 09/07/18 at 10:39 am with the registered nurse who provided infection control training for the facility. 2. Review of Staff B, MA's personnel records revealed: -Staff B was hired in September 2016. -There was documentation for completion of the annual state approved infection control training on 09/29/16. -There was documentation for completing 3 hours of "Blood Borne Pathogen" training dated 12/26/17. -There was no documentation for completion of the annual state approved infection control training for 2017. Interview on 09/07/18 at 5:30 pm with Staff B revealed: -She had not taken the annual state approved infection control training for 2017. -She took the training in 2016. -She had not taken the training yet in 2018. -The facility administration had arranged the training in 2016. -The facility administration told her she could take a blood borne pathogen course on the computer for 2017. Refer to the interview with the Administrator on 09/07/18 at 9:10 am. Refer to the telephone interview on 09/07/18 at 10:39 am.with the registered nurse who provided infection control training for the facility. Interview with the Administrator on 09/07/18 at 9:10 am revealed: -The state approved infection control training course had been taught by the contract Nurse on	D934		

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D934	Continued From page 16 09/26/18. -Staff had completed an online Blood Borne Pathogen course that was approved for 3 hours credit. -She thought the infection control training was available online now and the course she requested staff take was approved by the state. -She was going to schedule the contract Nurse to come to the facility to teach the required course. Telephone interview on 09/07/18 at 10:39 am with the registered nurse who provided infection control training for the facility revealed: -She had not taught the infection control training course for the facility since 2016. -The facility could call her to arrange for the 3 hour training. -She had not discussed an infection control training available on the web as an alternative to the state approved infection control training with the facility. -She knew the Blood Borne Pathogen course could be taken by staff for hours toward the required continuing education requirements.	D934		
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 interviews and record reviews, the facility failed to assure 1 of 3 medication aides sampled (Staff A) completed the 5, 10 or 15 hour medication training or had verification of previous employment before administering medication to	D935	Administration will see that all new staff will complete the 5 hr and 10 hr. classes as required by state. 10-1-18	

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D935	Continued From page 18 residents. The findings are: Review of Staff A, medication aide's personnel record revealed: -Staff A was hired on 03/08/17. -There was documentation Staff A completed a medication clinical skills validation on 03/28/17. -There was documentation Staff A successfully passed the medication administration exam on 08/26/13. -There was documentation of employment verification for working and passing medications at another facility dated 05/10/14, however the facility was not a licensed assisted living home or family care home. -There was no documentation of a 5, 10 or 15 hour medicationadministration training in Staff A's personnel record. Review of the July 2018, August 2018 and September 2018 Medication Administration Records revealed Staff A had documented administration of medications to the residents on a routine basis. Interview on 08/06/18 at 5:30 pm on with Staff A revealed: -She had passed the medication aide test in 2013. -She had worked as a MA at another facility from 2007 to 2010. -She had worked for her previous employer for 3 to 4 months until 05/10/14. -Her responsibilities were to administer medications to the residents in the facility, provide personal care services, and cook for the residents.	D935		

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D935	Continued From page 19 Interview on 09/06/18 at 5:00 pm with Co-Administrator (Staff C) revealed: -She was responsible for verification of employment or completing the required 5, 10, or 15 hour medication aide training course for staff newly hired for medication aide staff. -She accepted the employment verification form for Staff B, but did not know the employment could not be more than 24 months since working as a medication aide in an assisted living or family care home at time of hire. -She currently was requiring all newly hired medication aides to complete the 15 hours medication aide training prior to employment.	D935		