

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL045129	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 04/21/2023
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE GARDENS OF HENDERSONVILLE

**1000 WEST ALLEN STREET
HENDERSONVILLE, NC 28739**

(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 and complaint investigation with an onsite of 04/19/23-04/20/23, and desk review on 04/21/23 with a telephone exit on 04/21/23.	D 000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely as a matter of compliance with state laws	
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO A UNABATED TYPE B VIOLATION Based on these findings the previously unabated Type B Violation has not been abated. Based on observations, record reviews and interviews the facility failed to administer a medication for 1 of 3 sampled residents (Resident #2) for a medication used for pain control to be given in a titrated dose over the course of three weeks. The findings are: Review of the FL2 for Resident #2 dated 09/22/23 revealed diagnoses of epilepsy, alcohol induced dementia, dysarthria and anarthria (speech and language impairment), and hypertension.	D 358	An audit of Physician Orders and a cart audit was completed to ensure that Medication Administration Record (MAR) reflected the applicable orders. Any findings that a medication was not reflected correctly on the MAR was corrected and the Physician/Provider notified for any additional orders. The Executive Direct (ED) and the Resident Care Coordinator (RCC) were re-trained by the Area Clinical Director (ACD) on the procedures for approving orders, including the verification of receipt of	5/4/2023

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Gray E. Elliott

4/2/23

Executive Director

STATE FORM

Reviewed and acknowledged 06/05/23 rm

0N6Z11

If continuation sheet 1 of 20

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D 358	Continued From page 1 Review of Resident #2's otolaryngology (healthcare specialist who treats conditions affecting your ears, nose and throat) physician visit dated 03/20/23 revealed a diagnosis of malignant neoplasm of the base of the tongue (a cancerous tumor). Review of a physicians order note for Resident #2 on 03/29/23 revealed an order for gabapentin (used to treat pain) 300mg one capsule in the morning and 300mg one capsule at noon and 300 mg one capsule before bedtime. Review of a second physicians order sheet for Resident #2 dated 03/29/23 revealed: -An order to titrate gabapentin 300mg one capsule three times daily. -Initiate gabapentin for 300mg one capsule before bedtime for one week, then gabapentin 300mg one capsule in the morning and 300 mg one capsule in the evening before bedtime for one week, then gabapentin 300mg one capsule three times daily, morning, noon and evening before bedtime. Review of Resident #2's electronic Medication Administration Record (eMAR) for March 2023 revealed: -There was a computer generated entry for gabapentin 300mg one capsule three times daily scheduled for 8:00am, 12:00pm, and 8:00pm to begin on 03/30/23. -There was documentation on 03/30/23 gabapentin 300mg one capsule was administered at 12:00pm, and 8:00pm. -There was documentation on 03/31/23 gabapentin 300mg one capsule was administered at 8:00am, 12:00pm and 8:00pm . -There was no documentation of gabapentin 300mg being titrated as per physician order.	D 358	medication and implementation of the orders. The Resident Care Coordinator is responsible for approving orders and ensuring the order is implemented and reflected correctly on the MAR. The Executive Director reviews all orders on a weekly basis for the next 30 days to ensure all orders and/or treatments are processed timely and reflected accurately on the MAR. Executive Director continues to complete random audits of Physician Orders on a monthly basis.	5/4/2023

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D 358	Continued From page 2 Review of Resident #2's eMAR for April 2023 revealed: -There was a computer generated entry for gabapentin 300mg one capsule three times daily scheduled for 8:00am, 12:00pm, and 8:00pm. -There was documentation gabapentin 300mg one capsule was administered at 8:00am, 12:00pm and 8:00pm on 04/01/23- 04/18/23 and at 8:00am on 04/19/23. -There was no documentation of gabapentin 300mg being titrated per physician order. Interview with Resident #2 on 04/19/23 at 9:46am revealed: -He recently went to a neurologist because he had ringing in the ears and headaches and was diagnosed with cancer. -The neurologist ordered a new medication to treat the ringing in his ears and headaches. -He did not know the name of the medication or the dosage. -The facility's staff administered his medications. Interview with the facility's contracted pharmacy representative on 04/19/23 at 4:38pm revealed: -The pharmacy had received the order on 03/29/23 for the gabapentin 300mg one tablet three times daily. -They had also received the second order, dated 03/29/23 to titrate the gabapentin 300mg one tablet three times daily; for week 1 gabapentin 300mg capsule before bedtime, week 2 was for gabapentin 300mg one capsule in the morning and 300 mg one capsule before bedtime and week 3 was for gabapentin 300mg one capsule three times daily. -If the pharmacist had questions about the order they would have noted they called the physician about the order.	D 358		

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D 358	Continued From page 3 -There was no note about starting the gabapentin 300mg or clarification regarding the order. -The pharmacy had not entered the titration schedule into the eMAR system for Resident #2. -The titration dose should have been entered into the eMAR by the pharmacy but it was not, only the order for gabapentin 300mg one capsule three times daily. -The facility should have caught the mistake as they have to approve the order before the final entry goes onto the eMAR for Resident #2. Interview with a medication aide (MA) on 04/20/23 at 10:25am revealed: -She was not responsible to review the orders for residents when they returned from their physician's appointments. -When a resident returned from the physician's appointment all new orders were given to the Resident Care Coordinator (RCC) -The RCC was responsible to review the orders and notify the pharmacy. -She gave the medication as directed on the eMAR. -She did not recall titrating the gabapentin 300mg for Resident #2. Interview with Resident #2's guardian on 04/20/23 at 10:27am revealed: -She had attended the physician's appointment with Resident #2 on 03/29/23. -The physician started Resident #2 on gabapentin 300mg for his migraines. -The physician explained the gabapentin 300mg was to be titrated over a three week period to see if Resident #2 would be able to tolerate the new medication and reduce or eliminate any adverse side effect Resident #2 may experience. -She placed the orders in the folder for Resident #2 and gave them to the transportation driver that	D 358		

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D 358	Continued From page 4 returned Resident #2 from his physician's appointment on 03/29/23. -She had also sent an email dated 03/29/23 to the RCC about the new medication orders being placed in the folder for Resident #2. -She had received an email dated 03/29/23 from the RCC stating she had received the prescription for the gabapentin 300mg, she had sent it to the pharmacy, and the RCC had already profiled and approved the gabapentin and the medication was on its way to the facility. -She was aware the facility had not titrated the gabapentin 300mg as the physician had ordered. Interview with the RCC on 04/20/23 at 11:24am revealed: -When a resident was taken to the physician a folder was sent with the residents information and a blank physician order sheet for the physician to write any new orders. -If the physician had the facility's pharmacy information they could send the new order directly to the pharmacy. -If the physician could not send the prescription directly to the pharmacy the physician would return the new orders back to the facility in the resident folder. -She would then fax the orders to the pharmacy, the pharmacy would review and then send back to her for final approval before they were added to the eMAR. -Resident #2 was seen by to the neurologist on 03/29/23 and he had returned with a new orders for gabapentin 300mg. -She had received the order in the folder from the neurologist appointment and she sent the order to the pharmacy. -Once the pharmacy reviewed the orders the pharmacy sent the new order to her to approve. -She approved an order for the gabapentin	D 358			

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D 358	Continued From page 5 300mg three times daily and it had been entered on Resident #2's eMAR. -She was responsible to approve all the medication orders prior to them being added to the eMAR. -The medication aides only gave what she approved on the eMAR. -She did not recall the titration order for the gabapentin 300mg capsule for Resident #2. -She should have caught and corrected the order related to the titration instead of starting the gabapentin 300mg at the full prescription of 300mg three times daily. -"I just made a mistake." Follow up interview with Resident #2 on 04/20/23 at 11:59am revealed: -He was having difficulty with dizziness and his hands had begun to shake since he began the new medication. -He was concerned he would fall when he stood up because he was so dizzy. Telephone interview with the registered nurse (RN) for Resident #2's Neurologist on 04/21/23 at 1:51pm revealed: -On 03/29/23, Resident #2 was started on gabapentin 300mg for pain related to his migraines. -Gabapentin was a medication that was important to titrate because Resident #2 was such a medically complex resident and the neurologist wanted to ensure the resident was able to tolerate the gabapentin 300mg and avoid any adverse side effects. -The fact Resident #2 was verbalizing dizziness and his hands shaking was a direct result of receiving too much gabapentin all at once. -These symptoms were very common adverse side effects from the gabapentin.	D 358		

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D 358	Continued From page 6 -It was not safe "to dump that much gabapentin" on a resident and the neurologist always titrated this particular medication because it reacts differently with each resident. -The neurologist had written specific directions for this medication to be titrated and the neurologist had expected them to be followed. -She could not stress enough Resident #2 was a medically complex resident and that most of the damage had already been done as Resident #2 was experiencing adverse side effects after having been on the medication for several weeks now but it was very concerning that Resident #2 was still experiencing adverse side effects. The facility failed to administer medications as ordered to Resident #2 related to titrating gabapentin over a three-week period before starting a full dose as ordered by the physician to decrease or eliminate adverse side effects which resulted in dizziness and hand tremors for Resident #2. The facility's failure was detrimental to the health, and safety of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/20/23 for this violation.	D 358			
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the	D 366			

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D 366	Continued From page 7 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 observation, interviews, and record reviews, the facility failed to ensure a medication aide observed 1 of 1 resident (Resident #1) take medications administered resulting in medications left setting on the resident's bedside table in her room. The findings are: Review of the facility's policies and procedures for medication administration dated September 2021 revealed: -The resident's prescribing physician/provider would be immediately notified of medication errors including missed doses and wrong doses administered. -Any doses of medication prepared for administration and not administered shall be destroyed at the facility. -All medications must be kept in locked storage for the safety of all residents residing in the facility. -Missed medications were documented in the resident's medication administration record. -The medication aide would notify the prescribing provider of missed medications immediately. -There was no documentation regarding the facility's policy for leaving medications in a resident's room or not watching the resident swallow the medication after administration. Review of Resident #1's current FL2 dated 03/07/23 revealed: -Diagnoses included hypertension, gastroesophageal reflux disease, depression,	D 366	The Executive Director (ED) , Resident care Coordinator (RCC) and Medication Aides were re-trained by the Area Clinical Director (ACD) on Medication Administration policies and procedures, including the importance of observing the resident actually taking the medication prior to documentation of administering the medication. Area Clinical Director provided a medication administration observation on a weekly basis for the next 30 days.	6/9/2023

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D 366	Continued From page 8 bone deficiency, and neck pain. -There was no order for Resident #1 to self-administer medications. -There was a medication order for sertraline (used to treat depression) 50mg take 1 tablet daily. -There was a medication order for lisinopril (used to treat high blood pressure) 30mg take 1 tablet daily. -There was a medication order for a lidocaine patch (used to treat pain) 4% apply 1 patch to the neck daily and remove at bedtime. -There was a medication order for vitamin D3 (used to treat bone deficiencies) 1,000 units take 1 capsule daily. Review of Resident #1's physician's orders revealed: -There was an order dated 03/07/23 for omeprazole (used to treat heartburn) 20mg take 1 capsule daily. -There was an order dated 03/18/23 to increase the dosage of sertraline to 100mg daily. Observation of Resident #1's room during the initial tour of the facility on 04/19/23 at 9:27am revealed: -Resident #1 was lying in bed with her eyes open. -There was a plastic medication cup labeled with Resident #1's first name on the bedside table containing 3 tablets and 2 capsules. Interview with Resident #1 on 04/19/23 at 9:27am revealed: -Staff did not administer her morning medications on 04/19/23. -She could not see the bedside table from the angle of her bed and did not know if the night shift medication aide (MA) left her morning medications setting on the bedside table.	D 366		

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D 366	Continued From page 9 -Her morning medications were supposed to be administered by the night shift MAs since the medications were due at 7:00am. -The night shift MAs would sometimes forget to administer her medications and leave the medications in her room. -A night shift MA brought her morning medications to her room around 6:00am but did not administer the medications. -She was supposed to have a pain patch applied to her neck daily and the night shift MA did not apply the patch. Observation of Resident #1's neck on 04/19/23 at 9:31am revealed there was no medication patch present. Review of Resident #1's April 2023 electronic medication administration record (eMAR) revealed: -There was an entry for sertraline 100mg take 1 tablet daily at 7:00am and documented as administered on 04/19/23. -There was an entry for lisinopril 30mg take 1 tablet daily at 7:00am and documented as administered on 04/19/23. -There was an entry for omeprazole 30mg take 1 capsule daily at 7:00am and documented as administered on 04/19/23. -There was an entry for vitamin D3 1,000 units take 1 capsule daily at 7:00am and documented as administered on 04/19/23. -There was an entry for lidocaine patch 4% apply 1 patch to the neck daily at 7:00am and remove at 7:00pm and documented as applied on 04/19/23. Observation of Resident #1's medications on hand available for administration on 04/19/23 at 2:14pm revealed:	D 366		

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D 366	Continued From page 10 -There was a multi dose medication package labeled with the name and directions for each medication including lisinopril 30mg, omeprazole 30mg, sertraline 100mg, and vitamin D3 1,000 unit capsule. -There was a box of lidocaine patches 4% labeled to apply 1 patch to the neck daily at 7:00am and remove at 7:00pm. Interview with a MA on 04/19/23 at 9:42am revealed: -The night shift MA was responsible for administering Resident #1's morning medications since the medications were due at 7:00am. -She did not know there were medications sitting on Resident #1's bedside table. -MAs were responsible for watching residents swallow their medications when administering medications and then document the medications as administered on the eMAR. -The facility's policy for medication administration included to never leave medications in a resident's room. Interview with the Resident Care Coordinator on 04/19/23 at 4:13pm revealed: -The facility's policy for medication administration included administering the medications to the resident, watching the resident swallow the medications and apply the lidocaine patch then documenting the medications as administered on the eMAR. -Medications were not supposed to be left with residents to self-administer unless the resident had an order to self-administer medications. -She did not know the night shift MA left Resident #1's medications in Resident #1's room on 04/19/23. Telephone Interview with Resident #1's primary	D 366		

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D 366	Continued From page 11 care provider (PCP) on 04/20/23 at 10:58am revealed: -She was not notified by the facility of instances where Resident #1 missed doses of medications. -She expected the facility staff to notify her of missed doses of medications for residents. -Resident #1 was oriented and would know if she was not administered her ordered medications. -It was important for the facility to administer Resident #1's medications as ordered or notify her of missed doses so she could give alternate orders for the missed doses. -Resident #1 could experience high blood pressure causing kidney damage or increased risk of having a stroke from not receiving lisinopril 30mg daily to treat high blood pressure, increased depression and anxiety from not receiving the sertraline 100mg daily to treat depression and anxiety, increased pain from not receiving the 4% lidocaine patch applied to the neck to decrease pain, and increased heartburn from the missed omeprazole 30mg daily to treat heartburn. Interview with the Area Clinical Director on 04/20/23 at 11:30am revealed: -She did not know why the night shift MA left Resident #1's morning medications in Resident #1's room and did not administer the medications. -She expected staff to administer medications as ordered according to the facility's policies and procedures for medication administration. -She expected staff to document medications as administered on the eMAR after watching the resident take the medication. -The night shift MA was trained to administer medications as ordered and document on the eMAR the medications administered. -Staff were trained to not leave medications with a resident to self-administer unless the resident	D 366		

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D 366	Continued From page 12 had an order to self-administer. -The MA that discovered missed doses of medications was responsible for calling and notifying the PCP. Attempted telephone interview with a night shift MA on 04/19/23 at 3:10pm was unsuccessful.	D 366			
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure the electronic medication administration records	D 367	The community shall ensure the medication aide administering medications is also the medication aide that documents the medication as administered. All community medication aides have been in-serviced on medication administration policies and procedures by the Area clinical Director.	6/9/2023	

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NAME OF PROVIDER OR SUPPLIER THE GARDENS OF HENDERSONVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1000 WEST ALLEN STREET HENDERSONVILLE, NC 28739		
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D 367	Continued From page 13 (eMAR) was accurate for 1 of 1 resident (Resident #1) related to medications documented as administered when the medications were left setting on the resident's bedside table and the medication pain patch was not applied. The findings are: Review of the facility's policies and procedures for medication administration dated September 2021 revealed: -Missed medications were documented in the resident's medication administration record. -The medication aide would notify the prescribing provider of missed medications immediately. Review of Resident #1's current FL2 dated 03/07/23 revealed: -Diagnoses included hypertension, gastroesophageal reflux disease, depression, bone deficiency, and neck pain. -There was a medication order for sertraline (used to treat depression) 50mg take 1 tablet daily. -There was a medication order for lisinopril (used to treat high blood pressure) 30mg take 1 tablet daily. -There was a medication order for a lidocaine patch (used to treat pain) 4% apply 1 patch to the neck daily and remove at bedtime. -There was a medication order for vitamin D3 (used to treat bone deficiencies) 1,000 units take 1 capsule daily. Review of Resident #1's physician's orders revealed: -There was an order dated 03/07/23 for omeprazole (used to treat heartburn) 20mg take 1 capsule daily. -There was an order dated 03/18/23 to increase	D 367		

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D 367	Continued From page 14 the dosage of sertraline to 100mg daily. Observation of Resident #1's room during the initial tour of the facility on 04/19/23 at 9:27am revealed there was a plastic medication cup labeled with Resident #1's first name on the bedside table containing 3 tablets and 2 capsules. Interview with Resident #1 on 04/19/23 at 9:27am revealed: -She did not administer her morning medications on 04/19/23. -Her morning medications were supposed to be administered by the night shift medication aides (MAs) since the medications were due at 7:00am. -A night shift MA brought her morning medications to her room around 6:00am but did not administer the medications. -She was supposed to have a pain patch applied to her neck daily and the night shift MA did not apply the patch. Observation of Resident #1's neck on 04/19/23 at 9:31am revealed there was no lidocaine patch present. Review of Resident #1's April 2023 electronic medication administration record (eMAR) revealed: -There was an entry for sertraline 100mg take 1 tablet daily at 7:00am and documented as administered on 04/19/23. -There was an entry for lisinopril 30mg take 1 tablet daily at 7:00am and documented as administered on 04/19/23. -There was an entry for omeprazole 30mg take 1 capsule daily at 7:00am and documented as administered on 04/19/23. -There was an entry for vitamin D3 1,000 units	D 367			

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D 367	Continued From page 15 take 1 capsule daily at 7:00am and documented as administered on 04/19/23. -There was an entry for lidocaine patch 4% apply 1 patch to the neck daily at 7:00am and remove at 7:00pm and documented as applied on 04/19/23. Interview with a MA on 04/19/23 at 9:42am revealed the MAs were responsible for watching residents swallow their medications when administering medications and then document the medications as administered on the eMAR. Interview with the Resident Care Coordinator on 04/19/23 at 4:13pm revealed the facility's policy for medication administration included administering the medications to the resident, watching the resident swallow the medications and apply the lidocaine patch then document the medications as administered on the eMAR. Interview with the Area Clinical Director on 04/20/23 at 11:30am revealed: -She did not know why the night shift MA documented that she administered Resident #1's medications on the eMAR on 04/19/23 when the MA left the medications setting on Resident #1's bedside table. -She expected staff to administer medications as ordered according to the facility's policies and procedures for medication administration. -She expected staff to document medications as administered on the eMAR after watching the resident take the medication. -The night shift MA was trained to administer medications as ordered and document on the eMAR the medications administered or document the medications as not administered if they were not given or applied.	D 367			

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D 367	Continued From page 16 Attempted telephone interview with a night shift MA on 04/19/23 at 3:10pm was unsuccessful.	D 367		
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	D935	A complete audit of all medication aide files was completed immediately by the Business Office Coordinator Any medication aide found to not have successfully completed the medication examination developed and administered by the Division of Health Service Regulation was immediately removed from the medication cart until the medication aide successfully completed the medication exam and medication aide skill have been revalidated by the Area Clinical Director. Executive Director and Business Office Coordinator will eb retrained by the Regional Director of	6/9/2023

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D935	Continued From page 17 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 ensure 1 of 3 sampled staff who administered medications met the requirements related to passing medications within 60 days of hire. The findings are: Review of the facility's policy for medication aide (MA) training revealed: -MA's will need to register, take, and pass the medication state test within 60 days of the skilled check-off. -"Please assist them in registering for the Test Exam as they only have 60 days once signed off to take it and pass it, best to start this at the beginning of the training." -If the MA does not pass the state test within the 60-day period, they must immediately be removed from the cart. -Once they pass the test, they will be re-evaluated by the Registered Nurse (RN) before they can administer medications. Review of Staff A's personnel record revealed: -Staff A was hired on 09/29/23 as a personal care aide (PCA). -There was no job description for a MA in the personnel record. -There was documentation of a medication	D935	Operations on the Adult care Home Medication Aides; training and competency validation requirements. It is the responsibility of the Business Office Coordinator to ensure that all the required trainings, exams and other documentation is in the employee files. The Executive Director will monitor employee files on a monthly basis	

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D935	Continued From page 18 clinical skills validation checklist completed for Staff A on 01/25/23. -There was no documentation Staff A had passed the state approved medication aide test. Review of a resident's February, March and April 2023 electronic medication administration records (eMAR) revealed Staff A documented administering medications on 31 days from 2/15/22 to 04/19/23. Interview with the Regional Director of Operations on 04/20/23 at 11:40am revealed: -Staff A should have already taken the medication aide test. -The Business Office Manager (BOM) was responsible for all staff records including the medication aide testing. Interview with the BOM on 04/20/23 at 12:20pm revealed: -She was responsible for ensuring staff training and staff qualifications were in the staff personnel records. -Staff who passed their medication clinical skills were told they had 60 days to take their state approved test. -It was the staff members responsibility to sign up for, take the test and inform her when they had taken the test. -She was not responsible for ensuring staff took the medication aide test within the 60 days following their medication clinical skills were completed. Interview with the Resident Care Coordinator (RCC) on 04/20/23 at 3:41pm revealed: -She thought Staff A had taken the medication aide test on 04/18/23. -She had spoken with Staff A on 04/20/23 at	D935			

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE GARDENS OF HENDERSONVILLE

**1000 WEST ALLEN STREET
HENDERSONVILLE, NC 28739**

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D935	Continued From page 19 3:20pm and she had not taken the medication alde test and Staff A had not scheduled the test at this time. Attempted telephone interview with Staff A on 04/20/23 at 12:26pm and on 04/20/23 at 4:08pm was unsuccessful.	D935		