STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043003	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 1-2, 2015.	D 000		
D 152	10A NCAC 13F .0501 (d) Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (d) The facility shall assure that staff who perform or directly supervise staff who perform personal care receive on-the-job training and supervision as necessary for the performance of individual job assignments prior to meeting the training and competency requirements of this Rule. Documentation of the on-the-job training shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure the 80 hour personal care training and competency evaluation was completed within six months of hire for 1 of 3 Staff (A) sampled. The findings are: Review of Staff A's personnel file on 4/2/15 revealed: - Staff A was hired on 5/13/09 as a Personal Care Aide - Staff A is currently working as a Medication Aide. - There were no documentation of the Personal Care Services (PCS) 80 hour training. Interview with facility's Manager on 4/2/15 at 3:00 P.M. revealed: - Staff A had completed the necessary 80 hour training.	D 152		

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D 152	Continued From page 1 - Facility's Manager was unable to locate documentation of 80 hour training for Staff A by end of survey.	D 152		
D 166	10A NCAC 13F .0506 Training On Physical Restraints 10A NCAC 13F .0506 Training On Physical Restraints (b) Training shall be provided by a registered nurse and shall include the following: (1) alternatives to physical restraints; (2) types of physical restraints; (3) medical symptoms that warrant physical restraint; (4) negative outcomes from using physical restraints; (5) correct application of physical restraints; (6) monitoring and caring for residents who are restrained; and (7) the process of reducing restraint time by using alternatives. This Rule is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide training on physical restraints for 3 of 3 Staff (A, B, C) whose qualifications were reviewed. The findings are: Review of Staff A's personnel record revealed that she was hired 5/13/09 as a Personal Care Aide. Review of Staff B's personnel record revealed that she was hired 11/14/14 as a Personal Care Aide. Review of Staff C's personnel record revealed	D 166		

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D 166	Continued From page 2 that he was hired 10/24/14 as a Certified Nurses Assistant. Observation during the initial tour of facility on 4/1/15 between 9:15 A.M. and 11:00 A.M. revealed that there were two residents secured in bed with the use of full bedside rails: Interview with a Medication Aide (MA) on 4/1/15 at 10:45 A.M. revealed: - Both residents are total care resident who is unable to get out of bed without assistance. - The side rails are up for two residents for safety. Review of Physician Restraint Orders for both residents revealed: - The medical need for use of bedrails was to prevent injury or death from falls or entrapment. - For both residents restraints must be checked every 30 minutes while resident is in bed. - For both residents restraints must be loosened every one (1) hour. - For both residents restraints must be removed every two (2) hour. Interview with facility's Manager on 4/2/15 at 3:00 P.M. revealed: - She was not aware that the bedside rails were considered restraints. - Due to not considering bedside rails a restraint was not aware that staff had to have restraint usage training. - She will schedule with RN for staff to have the necessary restraint training.	D 166		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision	D 269		

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D 269	Continued From page 3 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to provide personal care for two of two bedbound residents (#2, #3) according to their care plans and turning every two hours as ordered as evident by the skin breakdown on their buttocks. The findings are: 1.Review of Resident #2's current FL-2 dated 04/19/14 revealed: - Diagnoses including Cerebrovascular Accident, Hypertension, Diabetes Mellitus II, Chronic Obstructive Pulmonary Disease, Dementia, Korsakoff Syndrome, Benign Prostatic Hyperplasia, Hyperlipidemia, History of Alcoholism. - Resident is intermittently disoriented. - Resident is non-ambulatory. - Resident needs assistance with bathing, feeding, dressing and total care. - Resident is incontinent of bladder and bowel. Observation of Resident #2 on 04/01/15 during the tour of facility between 9:15 A.M. and 11 A.M. revealed: - Resident #2 lying in a hospital bed with full side rails in the up position. - Resident #2 was lying flat on his back	D 269		

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D 269	Continued From page 4	D 269		

diagonally from the right side of the bed to the left side in hospital bed with a pillow behind his head with feet off of pillow with bunny boots on both feet.

Resident #2's Care Plan dated 4/19/15 revealed:
- Resident #2 was totally dependent on staff for eating, toileting, ambulation, bathing, dressing, grooming and transferring.
- Resident #2 is non-ambulatory or "bed ridden" .
- Resident #2 has limited strength in both right and left upper extremities.
- Resident #2 is also incontinent daily of bladder and bowel.

Interview with a Medication Aide (MA) on 4/1/15 at 10:45 A.M. revealed:
- Resident #2 is a total care resident who is unable to get out of bed without assistance.
- The side rails are up for Resident #2's safety.
- Resident #2 is checked, changed if necessary and repositioned every two hours.
- Resident #2 has a pressure sore dressing on buttocks that gets changed by a Home Health Nurse.

Review of Physician Restraint Order dated 3/11/15 revealed:
- The medical need for use of bedrails was to prevent injury or death from falls or entrapment.
- Resident #2's restraints must be checked every 30 minutes while resident is in bed.
- Resident #2's restraints must be loosened every one (1) hour.
- Then Resident #2's restraints must be removed every two (2) hour.

Observation of Resident #2 on 04/01/15 at 1:00 P.M. revealed:

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D 269	Continued From page 5 - Resident #2 lying in a hospital bed with full side rails in the up position. - Resident #2 was lying flat on his back diagonally from the right side of the bed to the left side in hospital bed with a pillow behind his head with feet off of pillow with bunny boots on both feet. Interview with a Personal Care Aide (PCA) on 4/1/15 at 1:30 P.M. revealed that Resident #2 is checked, changed if needed and turned every two (2) hour. Interview with Resident Care Coordinator (RCC) on 4/1/15 at 1:45 P.M. revealed: - Resident #2 is bedridden and does not get out of bed without staff assistance. - Staff is to check and turn Resident #2 every two (2) hours and provide incontinence care if needed. - These two (2) hour checks are to be documented on a turn schedule that is kept on a clipboard at resident ' s bedside. Interview with facility's Manager on 4/1/15 at 2:00 P.M. revealed: - Facility's staff checks on Resident #2 frequently as they pass his room. - Staff turns Resident #2 every two (2) hours and is supposed to document these turns. Review of Resident #2's two (2) hour turning schedule revealed: - That there were sheets for the turning schedule dated 3/4/15 to 4/1/15. - There were only four shifts that signatures showed that resident had been turned every two (2) hours. - All other shifts showed only one to two signatures for each shift.	D 269		

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D 269	Continued From page 6 Observation of Resident #2 on 04/01/15 at 3:30 P.M. revealed: - Resident #2 lying in a hospital bed with full side rails in the up position. - Resident #2 was lying flat on his back diagonally from the right side of the bed to the left side in hospital bed with a pillow behind his head with feet off of pillow with bunny boots on both feet. - Two PCAs came into Resident #2's room to provide care - Resident # 2 with dressing to the right medial of buttocks. - Resident #2 also had a reddened area approximately 30 cm on the left medial of buttocks. - The reddened area did not blanch and there was no open area or blister. - Staff applied some fanny cream that was at bedside to reddened area. - Resident was turned onto left side with pillow placed at back, pillow under head and pillow between legs with bunny boots on. Review of Home Health Nurse's (HHN) notes for Resident #2 revealed: - On 3/24/15 visit HHN documented that the heels skin were normal, discontinue foam and kerlix, and use bunny boots. - HHN also documented that sacral wound was healing. - On 3/31/15 visit HHN documented that "stage II to buttocks improving" . Review of Resident #2's Licensed Health Professional Support (LHPS) Quarterly Review dated 2/20/15 revealed that LHPS Nurse recommended getting resident up in wheelchair daily in order to meet his need.	D 269		

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D 269	Continued From page 7 Observation of Resident #2 on 04/02/15 at 9:30 A.M. revealed: - Resident #2 lying in a hospital bed with full side rails in the up position. - Resident #2 was lying flat on his back diagonally from the right side of the bed to the left side in hospital bed with a pillow behind his head with feet on pillow with bunny boots off both feet. Interview with facility's Manager on 4/2/15 at 9:40 A.M. revealed: - That staff is turning Resident #2 every two (2) hours but forgetting to document at times. - Resident #2's skin breakdown happens because when he is turned unto his side, he squirms until he gets back unto his back. Observation of Resident #2 on 04/02/15 at 11:10 A.M. revealed: - Resident #2 lying in a hospital bed with full side rails in the up position. - Resident #2 was lying flat on his back diagonally from the right side of the bed to the left side in hospital bed with a pillow behind his head with feet on pillow with bunny boots off both feet. Interview with Administrator on 4/2/15 at 6:35 P.M. revealed that he will ensure that staff is trained on the importance of turning and repositioning of residents every two (2) hours with the necessary documentation to ensure it is being done as instructed. 2. Review of Resident #1's current FL2 dated 11/13/14 revealed: - Diagnoses included dementia, history of falls and osteoarthritis. - She is described as intermittently disoriented, non- ambulatory, incontinent of bowel and	D 269		

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D 269	Continued From page 8 bladder. Review of Resident #1's resident register revealed she was admitted to the facility on 11/5/13. Resident's care plan dated 11/3/14 revealed: - Resident #1 was total care for eating, toileting, ambulation, bathing, dressing, grooming and transferring - Non-ambulatory, daily incontinence of bowel and bladder, limited strength. Observation of Resident #1 on the morning of 4/1/15 during the facility tour between 9:15 and 11:00am revealed: - Resident #1 lying in a hospital bed with full side rails in the up position. - She was lying flat on her back with a pillow behind her head and her feet up on a pillow. Interview with a medication aide on 4/1/15 at 10:00am revealed: - Resident #1 is a total care and cannot get out of her bed by herself. - She has side rails up to keep her from falling out of the bed. - She is turned by staff every 2 hours. - Resident #1 is being seen by a home health Nurse for dressing changes for a stage 2 decubitus to her bottom. Review of physician restraint orders dated 1/5/15 revealed: - Medical need for bedrails to prevent falls and injury and death from entrapment. - Resident #1 was to be checked every 30 minutes. - Resident #1 was to be loosened every 2 hours.	D 269		

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D 269	Continued From page 9 - She was to be removed every 1 hour Observation of Resident #1 at on 4/1/415 at 12:00pm revealed, Resident #1 lying flat on her back with a pillow behind her head and her feet up on a pillow. Interview with the facility Manager on 4/1/15 at 2:30pm revealed: - The facility's staff check on resident as they pass by the room. - The staff turn Resident #1 every 2 hours, they just do not document every time they turn her. Observation of Resident #1 on 4/1/15 at 2:45pm revealed, Resident #1 lying on her left side. Interview with the Resident Care Coordinator on 4/1/15 at 3:00pm revealed: - Resident #1 is bedridden and does not get out of bed. - Staff turn Resident #1 every 2 hours to meet the physician requirement for the resident to be loosened every 2 hours. - When staff is turning Resident #1 they provide incontinence care. - Staff document their 2 hour turn schedule on a sheet that is kept on a clip board at the resident ' s bedside. Review of the every 2 hour turning schedule for Resident #1 revealed: - The schedule was completed for 3/4/15 through 3/29/15. - There were nine days where all 3 shifts documented turning Resident #1 every 2 hour turns. - On five shifts from 3/6/15 first shift through 3/8/15 first shift staff documented the position Resident #1 was turned facing left or right.	D 269		

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D 269	Continued From page 10 - There were 17 days where 6 turns or less were documented for 24 hours. - There was no documentation provided to reveal staff turning resident 3/30/15 through 4/1/15. Observation of Resident #1 on 4/1/15 at 3:15pm revealed: - She was lying in bed on her back with a pillow behind her head and a pillow under her feet and she was wearing bunny boots. - Two personal care aides provided incontinence care and turned Resident #1 on her right side. - Resident #1 had a dressing to the left side of her buttock. - A red spot about the size of a fifty cent piece in the top middle of the buttock to the right of the dressing. - The red area was non- blanched and had no open area or blister. - One of the PCAs applied some fanny cream that was at the bedside. - Under the bunny boots Resident #1 had a dressing on the right side of her right ankle and her heels were soft, no redness or open areas noted. - Resident was turned onto her right side with a pillow placed behind her back and the pillow under her feet was repositioned. Review of the Home Health Nurse's notes for Resident #1 revealed: - She had been seeing Resident #1 for labs when she discovered a new stage 1 to the buttock on 12/19/14. She documented a pink area on the left side of Resident #1's buttock with no open area on it. - On 12/29/14 she found a new stage 2 on the buttock.	D 269		

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D 269	Continued From page 11 - Instructions to caregivers to do incontinence care and turn and reposition resident every 2 hours, and apply barrier cream until orders received from physician. - On 3/24/15 she documented the pressure ulcer to Resident #1's buttock to be in the healing stage, dried and scabbed. - She dressed the area with a hydrocolloid dressing. - She documented a healed pressure ulcer to Resident #1's bilateral heels. Observation of Resident #1 on 4/2/15 at 9:30am revealed Resident #1 lying flat on her back with a pillow behind her head and her feet up on a pillow. Interview with the facility Manager on 4/2/15 at 9:36am revealed: - Staff document turning Resident #1 and she believes they are turning her and forgetting to document. - Resident #1's skin is breaking down because she is immobile. - There is nothing the facility can do to avoid her skin breaking down. - Her skin breakdown is a part of the disease process. Interview with the administrator on 4/2/15 at 6:35pm revealed he will ensure the staff are trained on the importance of turning and repositioning residents every 2 hours, and the required documentation required to ensure it is being done properly. _____ Plan of Protection dated 4/2/15 revealed: - The manager will order appropriate wedges	D 269		

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D 269	Continued From page 12 and pillows for repositioning bed bound patients. - The Manager will have meetings with each shift immediately and make sure patients are checked, changed and turned regularly every two hours. - The manager will replace all flattened pillows they are currently using. - The residents will be changed every two hours and turned. - The residents will be checked on every 30 minutes. - All staff notified of all checks, changes and turns. - Also classes are being provided by Registered Nurse on restraints for all patient contact staff and supervisors. - We will ensure going forward that all staff have the tools and training to ensure patient safety and comfort at all times. _____ CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED May 17, 2015.	D 269		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the	D 276		

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D 276	Continued From page 13	D 276		

facility failed to implement physician orders regarding fluid restriction orders for 1 of 5 sampled residents (Resident #3). The findings are:

Review of Resident #3's current FL2 dated 10/15/14 revealed:
- Diagnoses included bipolar, anxiety, depression, seizure disorder and chronic obstructive pulmonary disease.
- Resident is oriented.

Review of physician's orders dated 10/15/14 revealed an order to restrict fluids for Resident #3 to 1 liter per day.

Review of the diet list for the facility revealed Resident #3 was on a fluid restriction of 1 liter per day.

Review of Resident #3's January, February and March 2015 Medication Administration Record (MAR) revealed:
- From 1/1/15 to 3/31/15, there were no documented fluid restriction totals.
- Each box of each was left blank.

Interviews with Resident #3 and 4 facility staff revealed Resident #3 was consuming more than 1 liter of fluid each day.

Observation of Resident #3 on 4/1/15 at 4:10pm revealed:
- Resident sitting out in the front yard drinking a 14 ounce (414 milliliter) cup of coffee.
- Resident pulled a 16oz. green tea out of her purse.

Interview with Resident #3 on 4/1/15 at 4:10pm revealed:

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	HAL043003	A. BUILDING: _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

(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 276	Continued From page 14 - Resident #3 says she is not on a fluid restriction. - She keeps a 14 ounce (oz.) coffee cup in her purse. - Facility staff give her (2) 14 oz. cups of coffee, and (1) 14oz. cup of tea each day. - Facility staff pour the coffee and tea for her. - She also drinks (2) 16oz. bottles of green, her family brings to the facility each day. - She also drinks water with crystallite in it at meal time. Interview with the Medication Aide (MA) on 4/2/15 at 9:35am revealed: - Resident #3 is on a fluid restriction. - She does not total fluids for Resident #3. - There are no sheets for staff to document fluid totals for Resident #3. Interview with the Facility Manager on 4/2/15 at 9:40am revealed: - She did not know Resident #3 was on a fluid restriction. - The Resident Care Coordinator (RCC) was responsible for making sure physician orders are implemented. - The RCC is no longer employed at the facility. Interview with the cook on 4/2/15 at 9:45am revealed: - Resident #3 is on a fluid restriction of 1 liter per day. - She fills Resident #3's coffee cup (14 oz.) up with coffee 3 times per day. - A pitcher of water is placed on the table at each meal, for the residents sitting at the table to share. - Resident #3 gets a 5oz. cup placed on the table for her to help herself with water.	D 276		

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D 276	Continued From page 15 - Resident #3 does not get anything to drink at snack times. - She does not write down how much fluid she is giving Resident #3 to drink. Interview with a personal care aide (PCA) on 4/2/15 at 10:00am revealed: - Resident #3 gets (1) 5oz. cup of water or tea, just at lunch time. - Resident is not given a drink at snack. - Her daughter brings green tea that she stores in her refrigerator. - She had given Resident #3 a half cup of coffee in her 14oz cup and she (Resident) fills it the other half with water herself. - She had never seen a sheet to total Resident #3's beverages on. Interview with a second PCA on 4/2/15 at 10:50am revealed: - She was aware Resident #3 was on a 1 liter per day fluid restriction. - She would tell Resident #3 she could only have (1) 5oz. cup of fluid at each meal. - She had not put anything in the coffee cup that Resident #3 keeps in her purse. - She had not seen any documentation of fluids or daily totals for Resident #3. Interview with a third PCA on 4/2/15 at 11:00am revealed: - She was aware Resident #3 was on a 1 liter per day fluid restriction. - She gives Resident #3 a small cup of orange juice for breakfast, tea for lunch and a half of the coffee cup she keeps with her of coffee at lunch. - She had never written down totals of what resident #3 had been given, she just told the RCC. - There is a pitcher of water placed on each	D 276		

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D 276	Continued From page 16 table in the dining room, she does not know if Resident #3 drinks it or not. Interview with the Administrator on 4/2/15 at 6:35pm revealed: - He was not aware of a fluid restriction order for Resident #3. - He will make sure staff is totaling her fluids from this point on. Attempts to contact physician for interview was unsuccessful.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure medication was administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 1 of 5 residents (#5) including not administering scheduled pain medication as prescribed. The findings are: Review of Resident #5's current FL-2 dated 3/31/14 revealed: - Diagnoses including Bipolar Disorder,	D 358		

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D 358	Continued From page 17 Hypertension, Gastroesophageal Reflux Disease, Diabetes Mellitus, Reynaud, Benign Prostatic Hyperplasia, Insomnia, Hepatitis C, Hypothyroid, Arthritis, Post Traumatic Stress Syndrome. - An order for Oxycodone IR 10 mg, one tablet by mouth four times daily. (Oxycodone is used to treat moderate to severe pain.) Review of Resident #5's Medication Administration Record (MAR) for February and March 2015 revealed: - Oxycodone was scheduled four times per day at 6:00 A.M, 12:00 Noon, 6:00 P.M. and 12:00 Midnight. - Documentation Resident #5 refused all midnight doses of Oxycodone starting 2/4/15 thru 3/31/15. Interview with Resident #5 on 4/2/15 at 12:37 P.M. revealed: - Resident #5 no medication at midnight. - He receives his last medications at 9:00 P.M. - Resident #5 states that he receives "no medication at night". - He is supposed to take his Oxycodone 3 times per day. - His Oxycodone is given at 6:00 A.M., 12:00 Noon and 4:00 P.M. - He has never refused any medications at night. Observation of Resident #5 on 4/2/15 at 12:37 P.M. revealed no sign or symptom or complaint of pain. Interview with a Medication Aide (MA) dated 4/2/15 at 12:49 P.M. revealed: - Resident #5 received Oxycodone HCL 10 mg one tablet four times per day at 7:00 A.M., Noon, 4:00 P.M. and 8:00 P.M.	D 358		

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D 358	Continued From page 18 - According to Resident #5's MAR, resident refused Oxycodone at midnight. - Physician was aware that Resident #5 has been refusing his nightly dose of Oxycodone. - Facility's policy and procedure is to make the physician aware that resident is refusing medication after 3 missed doses. Review of the controlled substance log for Resident #5 revealed that no Oxycodone was signed out for his midnight dose. Observation of Oxycodone count revealed that at the ime of the count there were 84 tablets remaining on medication cart. Review of hospital discharge medication list dated 3/20/15 revealed an order for Oxycodone HL 10 mg orally three times daily. Interview with a MA on 4/2/15 at 1:20 P.M. revealed: - That she was not aware of new order for Oxycodone dated 3/20/15. - There was no clarification of order made for Oxycodone. Interview with facility's Manager on 4/2/15 at 2:15 A.M. revealed: - Staff is to notify physician when a resident continuously refuses their medication. - When there is an order on a resident's hospital discharge medication list that is different than on the resident's MAR staff should get clarification from resident ' s primary care physician. - Did know why the order for Oxycodone was not clarified for Resident #5.	D 358		

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D 358	Continued From page 19 Attempts made to contact physician for interview was unsuccessful.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate and in compliance with rules and regulations as related to personal care and supervision. The findings are: Based on observation, interview and record review, the facility failed to provide personal care for two of two bedbound residents (#2, #3) according to their care plans and turning every two hours as evident by their skin breakdown on their buttocks. [Refer to tag D269, 10A NCAC 13F.0901(a) (Type B Violation).]	D912		