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
	HAL043003	A. BUILDING: ____ B. WING ____	10/18/2016

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

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on October 6, 7, 17, and 18, 2016.	D 000		
D 150	10A NCAC 13F .0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure that all staff required to have Personal Care Aide 80 hours training course had completed the course within six months after hire for 2 of 3 sampled staff (Staff B and Staff D).	D 150		

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D 150	Continued From page 1 The findings are: 1. Review of Staff B's personnel file revealed: -Staff B was hired at the facility on 02/19/16 as a Medication Aide and Personal Care Aide. -Staff B was not listed on the Registry as a Nursing Assistant. -There was no documentation in Staff B's Personnel file that Staff B had any Personal Care Aide training. Attempted interview with Staff B on 10/18/16 at 9:36 AM revealed that Staff B was unavailable to be interviewed at this time. Interview with the Administrator on 10/18/16 at 8:39 AM revealed: -She felt that staff received the 80 hours of Personal Care Aide training. -Staff B had received her training at another facility prior to working at this facility. -She had called the other facility to obtain the training but the other facility was unable to locate the training to send to her. 2. Review of Staff D's personnel file revealed: -Staff D was hired at the facility on 04/02/12 as a Personal Care Aide. -Staff D was not listed on the Registry as a Nursing Assistant. -There was no documentation in Staff D's Personnel file that Staff D had any Personal Care Aide training. Attempted interview with Staff D on 10/18/16 at 9:34 AM revealed that Staff D was unavailable to be interviewed at this time. Interview with the Administrator on 10/18/16 at	D 150		

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D 150	Continued From page 2 8:39 AM revealed: -Staff D had been trained when she was first hired but her chart had been thinned and it was packed away in storage and she could not locate where it had been packed away. -The training center where Staff D had done her Personal Care Aide training had closed down and she was unable to obtain another copy. -If was her responsibility to make sure that all staff had received their 80 hours of Personal Care Aide training within the first six months after hire. -She was going to try and schedule both of them to receive the training as soon as possible.	D 150		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure residents were spoken to in a respectful manner by staff (Staff C,D, and F). The findings are: Confidential interview with four residents revealed: -Staff C, Transporter was "very rude" to them when she spoke to them. -Staff C would tell the residents "she ain't got time" or "she always say she's got somebody else" when asked to take the residents to the store. -Staff C had certain people she would take to the	D 338		

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store when asked.
-Staff C would only take the residents to the store on their own time and not when those residents requested to go to the store.
-She never had time to talk with them and was "mean to them" when she responded to their questions.
-Staff C showed "favoritism" by only taking time with the residents she liked.
-Staff C only talked "nice" to the residents she liked.
-She made them feel "bad" about themselves when she would ignore them or speak "rudely" to them.
-They found other staff to help them as often as they could because Staff C was "mean" to them.

Telephone interview with Staff C on 10/18/2016 at 11:30am revealed:
-There were residents at the facility that at times wanted her to make special trips to the store and she could not always accommodate the residents' request.
-She sometimes would tell a resident she had been to the store three times that day.
-She had scheduled times to take residents to the store, usually on the 3rd, 4ht, and 5th of the month.
-There had been times when as soon as she returned with one resident, another resident would want to go to the store.
-Sometimes when residents wanted to go to the store she would fit them in when taking residents to physician appointments.
-Sometimes residents would "catch" her when she was going home and ask to go to the store, and she would tell the residents she would take them the next day.
-She was not aware of any resident complaints

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about her talking bad to the resident.
-She had not experienced any other staff talking rude to any residents.
-She was aware of one resident who thought she was "very mean" because the resident thought she was responsible for a previous physician terminating services with the resident, which was not true.
-The resident complained to the onsite Administrator about her being mean.
-She would report it to the onsite Administrator if a resident complained to her that a staff had been rude.

Confidential interview with a resident revealed:
-Staff D was "real critical" of the resident.
-Staff D called the resident "evil".
-The resident thought Staff D thought there was "a devil" in the resident.
-The resident felt "bad" when Staff D would say "stuff like that".
-Staff D was not a bad person but would get "irritated" with the resident.
-The resident found out if the resident talked nice to staff, then staff were okay.

An interview with Staff D was initiated on 10/6/2016 at 3:15pm. Staff D stated she needed to return to work. The interview could not be completed.

A telephone interview was attempted with Staff D on 10/18/2016 at 11:20am, but was unsuccessful.

Confidential interview with a resident revealed:
-Staff F rushed the resident to get ready in the mornings and would "fuss" at the resident to "hurry up".
-She made the resident "feel bad for having to move slowly" because of the residents' size and

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weight.
-The resident "could not help that [the resident] moved to slow" for Staff F but it did not make a difference in how she treated the resident.
-The resident had not told anyone because the resident "did not want any trouble from anyone at the facility".

Interview with Staff F on 10/07/16 at 8:15 a.m. revealed:
-She was not aware of any reaident having a concern about her.
-She "loves" all of the residents and they would come and talk to her and "ask for her" when she was not there.
-When she assisted residents with the morning routine, she would talk with the residents and "tried to help them smile."
-She was never in a "hurry" or "rushing" when working with the residents.

Observations of Staff F's interactions with the residents on 10/07/16 from 8:30 a.m.-9:00 a.m. revealed Staff F was friendly and courteous toward the residents and she assisted those who asked for assistance while in the dining and kitchen areas in a positive manner.

Confidential interviews with four staff revealed:
-Residents had not complained about other staff.
-Some residents at the facility "can give you a hard time".

Confidential interview with three facility visitors revealed:
-A resident told a visitor that the onsite Administrator was "short and kirt a lot of times".
-The onsite Administrator would "snap at residents".
-The visitor did not remember any specific

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resident names.
-The visitor had not seen the onsite Administrator be short, kirt, or snap at a resident firsthand.

Interview with the Resident Care Coordinator (RCC) on 10/18/2016 at 12:15pm revealed:
-She did not remember any resident complaints of any staff, including Staff C and Staff D, talking rude or ugly to them.
-She was aware some residents did not like Staff C, but the RCC did not know why.
-She had no awareness of anybody being rude to residents.
-She would talk to the staff and residents if there had been such a complaint, and staff would be disciplined.

Interview with the onsite Administrator on 10/18/2016 at 12:50pm revealed:
-No residents had ever told her that Staff C or Staff D had been rude, ugly, or made them feel bad about themselves.
-There were four or five residents at the facility that did not like Staff C because Staff C would not take them or stop by the store for them when the residents asked Staff C to.
-The onsite Administrator knew Staff C "had a run in" with a couple of residents because an outside transportation provider did not show up to take the resident to an appointment.
-Residents "blame and get upset" with Staff C when their appointments were rescheduled by the transport service.
-Staff C had a "big mouth" which meant she spoke "loudly" to staff and residents.
-She could see how Staff C's tone of voice could be taken the "wrong way".
-Staff C talked "that way when she spoke to others".
-A resident had told the onsite Administrator that

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D 338	Continued From page 7 the resident did not want Staff D to assist with care because Staff D "had a big mouth" . The resident also said about Staff D "I can't stand that 'n word', she won't make my bed". The Administrator stated this resident was no longer at the facility. -The onsite Administrator had talked to Staff D and told her she needed to talk in a softer tone, and she (onsite Administrator) could see where Staff D was being mis-interpreted. -She did not know why residents would not tell her if a staff had been rude or ugly because she had an "open door policy". -The facility held a mandatory training on resident rights on 06/28/2016 but Staff C did not attend.	D 338		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to treat all residents with respect, consideration, and dignity as it relates to the way staff spoke to residents. The findings are: Based on observations and interviews, the facility failed to assure residents were spoken to in a respectful manner by staff (Staff C, D, and F). [Refer to Tag D 0338 10A NCAC 13F .0909 Residents' Rights].	D911		

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D992	Continued From page 8	D992		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on observations, interviews, and record	D992		

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D992	Continued From page 9 reviews the facility failed to assure that 1 of 2 sampled staff (C) had received a substance abuse drug screening prior to hire. The findings are: Review of Staff C's personnel file revealed: -Staff C was hired at the facility as a transporter on 11/05/2013. -There was no documentation that Staff C had received a drug Screen. Interview with Staff C on 10/17/16 at 4:28 PM revealed: -Staff C was not sure of her exact hire date but she had been working at the facility for 3 years. -She did not remember getting a drug screen done when she was hired. -She did receive a drug screen on 10/06/2016. -She was unaware that a drug screen had to be completed prior to hire at the facility. Review of a facility laboratory result revealed: -Staff C had received a drug screen at the facility on 10/06/16. -The result for the drug screen was negative. Interview with the Administrator on 10/17/16 at 9:35 AM revealed: -She did not feel that Staff C had received a drug screen when she was first hired at the facility. -The Resident Care Coordinator (RCC) usually did the drug screens and was responsible for making sure they were done. -The RCC that would have been responsible for Staff C's drug screen no longer works at the facility. -It was her responsibility and the RCC's responsibility to make sure all staff required to have drugs screens had their drug screens done	D992		

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D992	Continued From page 10 prior to hire.	D992		