

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL043003	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 10/18/2016
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NAME OF PROVIDER OR SUPPLIER JOHNSON BETTER CARE FACILITY, INC.	STREET ADDRESS, CITY, STATE, ZIP CODE HWY 301 NORTH DUNN, NC 28335
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D 000	Initial Comments	D 000		
D 150	<p>10A NCAC 13F .0501 Personal Care Training And Competency</p> <p>10A NCAC 13F .0501 Personal Care Training And Competency</p> <p>(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.</p> <p>(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.</p> <p>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).</p>	D 150	<p>For more than a year we have vigorously tried to find classes, at community colleges, nursing companies, private institutions and our local DSS to no avail. We contacted [redacted] also to no avail. Nobody or agency are providing PCS training anymore. We will be requesting an extension for Staff B and D from [redacted] in the next 30 days.</p>	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

8899

2DKR11

1/5/17

If continuation sheet 1 of 11

Reviewed and accepted with addendum on 01/25/2017. - HF

Division of Health Service Regulation

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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	We will continue to provide as many CEUs as possible in relation to PCS training until a resolution can be reached on a PCS trainer is provided or available for hire. Staff B's certification from her prior facility is still unattainable at this time. Staff C, D & F will receive Residents Nights Training on Dec 7th 2016.	
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Division of Health Service Regulation

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2DKR11

If continuation sheet 2 of 11

*1/25/17 110% - Joseph conversation with Julian Johnson. Addendum as follows:
DQC is 01/25/2017.
Step B & D will be moved to positions in the facility that do not require providing or supervising personal care for residents. Step B & D will remain in those non-personal care positions until the required 80-hour personal care training course has been completed.
The prospective date of completion for the course is 3/7/2017. All new hire will be required to have the 80 hr. personal care training course on file by 3/7/2017.*

Division of Health Service Regulation

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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. -It 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	<p>The Administration and RCC had meetings with Staff F, C & D. All 3 Staff were very surprised and shocked as were we the supervising staff. All residents and staff are encouraged to come to the office or the RCC if they have private concerns. We also have a monthly resident council meeting for complaints & recommendations etc. Staff C does have a very high pitched (loud) voice,</p>	
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		

Addendum per telephone conversation with Jillian Johnson on 1/25/17 at 11:05 am:
 ① Resident Rights training was completed on 12/7/2016. ② Staff's C, D, and F attended the 12/7/2016 training along with all new hires. ③ All staff will be required to complete resident rights training annually. ④ Doc to 12/7/2016.
 - HF

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D 338	<p>Continued From page 3</p> <p>store when asked.</p> <ul style="list-style-type: none"> -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. <p>Telephone interview with Staff C on 10/18/2016 at 11:30am revealed:</p> <ul style="list-style-type: none"> -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, 4th, 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 	D 338	<p>and a very busy Doctor & Dental schedule, which is why we enlisted the help of [REDACTED] transport services. Unfortunately they are very unreliable and either show up 5 hours early or late or not at all. They are working on this issue. Staff C was being blamed for this issue by some residents. After speaking with several staff, and residents none of them had ever witnessed this behavior from Staff C.</p>	

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D 338	<p>Continued From page 4</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>A telephone interview was attempted with Staff D on 10/18/2016 at 11:20am, but was unsuccessful.</p> <p>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</p>	D 338	<p>However we did talk about how the deciple of her voice could easily be miscastrued and she is going to do her best to work on the deciple of her voice. Staff C is only allowed to take patients to the store on approved days or if they are last minute request she can take them on her way to or back from Doctors appointments. We simply cannot go to the store 4-5 times a day. However we do our best to at least have other staff go for them on a daily Basis.</p>	

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D 338	<p>Continued From page 5</p> <p>weight.</p> <ul style="list-style-type: none"> -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". <p>Interview with Staff F on 10/07/16 at 8:15 a.m. revealed:</p> <ul style="list-style-type: none"> -She was not aware of any resident 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. <p>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.</p> <p>Confidential interviews with four staff revealed:</p> <ul style="list-style-type: none"> -Residents had not complained about other staff. -Some residents at the facility "can give you a hard time". <p>Confidential interview with three facility visitors revealed:</p> <ul style="list-style-type: none"> -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 	D 338	<p>After speaking with Staff D, about the situation she explained that this particular resident does not like her, but she would never state those things to anyone or get irritated. However, she did request that her colleges go into the patients room with her when providing care as the patients would get ill with her, but if a co-walker was there she was fine. She did not think to tell her supervisor as she walked out that the patient liked or was happy when there were 2 aides in the room.</p>	

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D 338	<p>Continued From page 6</p> <p>resident names.</p> <p>-The visitor had not seen the onsite Administrator be short, kirt, or snap at a resident firsthand.</p> <p>Interview with the Resident Care Coordinator (RCC) on 10/18/2016 at 12:15pm revealed:</p> <p>-She did not remember any resident complaints of any staff, including Staff C and Staff D, talking rude or ugly to them.</p> <p>-She was aware some residents did not like Staff C, but the RCC did not know why.</p> <p>-She had no awareness of anybody being rude to residents.</p> <p>-She would talk to the staff and residents if there had been such a complaint, and staff would be disciplined.</p> <p>Interview with the onsite Administrator on 10/18/2016 at 12:50pm revealed:</p> <p>-No residents had ever told her that Staff C or Staff D had been rude, ugly, or made them feel bad about themselves.</p> <p>-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.</p> <p>-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.</p> <p>-Residents "blame and get upset" with Staff C when their appointments were rescheduled by the transport service.</p> <p>-Staff C had a "big mouth" which meant she spoke "loudly" to staff and residents.</p> <p>-She could see how Staff C's tone of voice could be taken the "wrong way".</p> <p>-Staff C talked "that way when she spoke to others".</p> <p>-A resident had told the onsite Administrator that</p>	D 338	<p>In the future she will notify a supervisor of any concerns. All patients are encouraged to privately or in council meeting each month to make complaints or recommendations to improve quality of care. We also talked about the deciple of her voice and how it could be misinterpereted. She will continue to work on this. She will also take the resident rights class again on Dec 7th 2016, this will be required Annually.</p> <p>D338 RCC & Administrator are responsible to ensure resident rights are maintained per rule. Monitored Monthly at resident council meetings, to prevent incidents going forward.</p>	

Division of Health Service Regulation

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D 338	<p>Continued From page 7</p> <p>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.</p> <p>-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.</p> <p>-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".</p> <p>-The facility held a mandatory training on resident rights on 06/28/2016 but Staff C did not attend.</p>	D 338	<p>Staff F has never been seen or heard by Staff or patients to be rude ever. She is always happy the patients ask when she's back in work on her days off, some of them even text and call her cell phone. She takes them to the store all the time lets a, colors their hair, shops for their personal items after work and really goes above & beyond ever cooking them something they have bought at the store that day. She will also attend the residents Right training again on Dec 7th 2016.</p>	
D911	<p>G.S. 131D-21(1) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights:</p> <p>1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.</p> <p>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.</p> <p>The findings are:</p> <p>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].</p>	D911		

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D992 D992	Continued From page 8 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.	D992 D992	<p><i>Staff 7 will pay attention to make sure no-one feels rushed at any time.</i></p> <p><i>RCC and administrator will check in with patients monthly at our resident council meetings to ensure all patients are aware the can come privately to the office if they have any complaints.</i></p> <p><i>Addendum to tag 992 per telephone conversation with Felicia Johnson on 1/25/17 at 11:08am.</i></p> <p><i>① The Administrator and Resident Care Coordinator will be responsible to ensure examination and screening for presence of controlled substances is completed for all new hire.</i></p> <p><i>② All drug screening will be done</i></p>	

prior to hire.

③ Doc will be 10/18/2016.

- 146

Division of Health Service Regulation

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D992	<p>Continued From page 9</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure that 1 of 2 sampled staff (C) had received a substance abuse drug screening prior to hire.</p> <p>The findings are:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	D992	<p>Staff C was hired one month after the rule was initiated. This was an oversight on part of the RCC which will not happen again. Administrator will follow up on all new hires to ensure the rule is followed.</p>	

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D992	<p>Continued From page 10</p> <p>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 prior to hire.</p>	D992	<p><u>D150</u> <u>Cont'd.</u></p> <p>RCC and Administrator will be responsible going forward.</p> <p>RCC and Administrator will continue with follow up prior to start date of every new hire to prevent future problems.</p> <p>RCC and Administrator will monitor this vigorously to make sure it does not happen again.</p> <p>Prospective completion date for PCS training is 03/7/17. Administrator is also trying to hire <u>Only</u> <u>Qualified</u> staff who have already obtained their PCA or CWA certification.</p>	