Division of Health Service Regulation | FORM APPROVED

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 ______	R 11/25/2019

NAME OF PROVIDER OR SUPPLIER: **JOHNSON BETTER CARE FACILITY, INC.**

STREET ADDRESS, CITY, STATE, ZIP CODE: **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 and follow-up survey on November 20, 2019 through November 22, 2019 with an exit conference via telephone on November 25, 2019.	D 000		
D 119	0A NCAC 13F .0311(j) Other Requirements 10A NCAC 13F .0311 Other Requirements (j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices. This rule applies to new and existing facilites. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents unable to evacuate without staff assistance were provided a hand bell or other signaling device. The findings are: Review of Resident #6's current FL2 dated 10/21/19 revealed diagnoses included cerebral infarction, chronic kidney disease, and gastroesophageal reflux disease (GERD). Observation of Resident #6 during the medication pass on 11/21/19 at 11:12am revealed: -Resident #6 walked down the hall towards the medication cart and told the medication aide (MA) that he was having chest pain. -She asked Resident #6 if he wanted a nitroglycerin tablet (used to treat chest pain). -Resident #6 stood by the mediation cart while the MA found the medication. -The MA was prompted that the resident may need to sit down if he was having chest pain.	D 119		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: Jan 14, 2020

Reviewed and Accepted 01/29/20 RH

Tag. 119 10A 13 F .0311 (j) Other Requirements

Johnson Better Care staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan, and current symptoms.

BOM and RCC immediately began to review and identify each resident to determine those at risk for falls and who are mentally or physically unable to evacuate without assistance and ensure appropriate interventions were put in place, including supervision and hand bells. The identified residents were given hand bells. BOM and RCC or designee to conduct weekly falls meeting to review effectiveness of interventions and to review newly identified residents at risk for falls.

These meetings will be documented and reviewed with the Administrator. A Hotspot communication log has been implemented and will be checked daily for any changes in resident's status that need to be addressed.

BOM and RCC of designee will conduct daily rounds to ensure supervision is being provided in accordance with the residents' needs. Fall prevention training was provided for the staff on 12/17/19. All newly hired staff will attend this training going forward.

Tag. 164. 10A NCAC 13F .0505

POP on 11/22/19. Med Tech's were supervised for med passes until training was completed on November 25th 2019 for Diabetic Care. All medication related staff attended this class.

See attached class outline for state requirements. This training is covered in the 15 hour training that all staff attended.

All online CEU's from Relias online training for current staff has been completed by all staff. The deadline for the annual completion was 12/31/19.

BOM and RCC or designee will monitor staff going forward to ensure training is up to date and in compliance with rules. This will be monitored monthly by BOM and RCC or designee.

See attached classes and outline of classes.

corrected 11/25/19.

D. 165. 10A NCAC 13F .0506 Physical Restraints

Physical restraints have been removed, and appropriate safety measures put in place including increased supervision and floor mats. Patients were also given bells and encouraged to ring bells when they needed assistance. The facility will ensure that if a restraint is ordered for a resident as a last resort, the staff will receive appropriate training. This will be monitored by the BOM, RCC or designee to ensure compliance with the rules going forward.

D. 271. 10A NCAC 13F .0901 Personal Care and Supervision

Refer to Tag. 119.

A Hotspot documenting method was implemented by the facility BOM and Administrator. Staff have been trained on how to use this form. All concerns are to be documented in Hotspot document. These reports will be checked daily by BOM and RCC to ensure follow up measures are taken to address concern immediately.

A laundry position has been created so aides can spend more time supervising and assisting residents.

Weekly meetings will be held to ensure tools are being used and to monitor outcomes for the first 90 days and monthly meetings thereafter.

All staff received Residents Rights training on 12/3/19 by Intrepid Health Services.

D. 276. 10A NCAC 13F .0902 © (3-4) Healthcare

BOM and RCC audited all orders immediately against EMAR system to ensure accuracy.

RCC will be responsible for tracking orders daily to ensure all orders are followed and documented.

All orders will be signed and dated by person reviewing and faxing orders to Pharmacy or doctors' offices.

They will also print a fax confirmation and attach it to ensure completion.

Pharmacist came from contracted LTC Pharmacy on 12/23/19 to go behind BOM and RCC to ensure accuracy.

Meeting held with all staff to ensure they follow through all orders and provide documentation of same. Staff will encourage all residents of the importance of treatments deemed necessary for health and safety.

A new recliner was purchased for #1 to encourage leg elevation. #1's PCP advised he still will not use his compression pump.

Staff will continue to encourage residents and try to re-direct when they do not like the taste, smell, or consistency of medication or treatment.

Staff will explain what it is for and the potential health outcomes and report to RCC or BOM. If resident still refuses, resident will be requested to sign a refusal form when refusing treatment or medications.

Corrected on 12/23/19.

Tag 282. .0904. (a) (1) Nutrition and Food Service

Harnett County Health Department re-inspected the facility on 11/21/19 and the facility received a 95 (A).

A plastic box was purchased and sanitized. The scoops are sealed in the box when not in use.

All containers are labelled and dated. All containers have been cleaned and sanitized or replaced with new ones.

A conversation was had with HC Health Inspector on 12/31/19 in relation to contamination potential from food containers states this is not an issue.

The kitchen is cleaned daily. A new ice machine cleaning log has been implemented. BOM or designee will monitor kitchen daily.

Corrected on 11/21/19.

Tag. D316 10A NCAC 13F. .0905 © Activities Program

There are 16 hours of scheduled activities per week. The karaoke was rescheduled and completed on 11/23/19 (hosted by BOM), as RCC was not feeling well.

Residents go to stores and eateries every day Monday-Friday. Residents go to Walmart per request at least 1 day a week.

Staff will continue to encourage participation in activities and all staff will participate in activities. Resident council meetings are held each month. Meetings were last held on the following dates:

11/16/19 at 9:30-10:30 a.m., 12/11/19 at 9:30-10:30 a.m., and 01/08/20 at 9:30-10:30 a.m. All residents will be encouraged to attend and suggest new activities they would like to do.

Facility will organize and reinstate visits to the cinema or bowling every other month.

Activities director has received a reduced schedule on RCC duties to attend more activities. BOM will take over RCC duties. New BOM hired on 01/13/20 (start date).

Corrected on 12/4/19.

Tag. D.338 10A NCAC 13F. .0909 Residents Rights

New Administrator hired on December 21st. New BOM hired with a start date of 01/13/2020. Assistant Administrator to attend NCALA's AIT Program in February. Immediately reviewed all staff with any allegations or write ups for misconduct, abuse, and neglect accusations. Staff have been relieved of duty.

Current BOM and RCC trained in how and when to do a 24 hour and 5 day report to HCPR per rules and regulations and company policy on 12/23/2020.

24 hour report was completed on these allegations on DSS, HC Sheriff Department, PCP and family members all notified of allegations. This investigation is ongoing and pending outcome.

All staff attended a Resident's Rights in service by Intrepid on 12/3/19. All staff to notify supervisors, BOM or RCC of any allegations of abuse or neglect by a resident, their family, staff and visitors.

Activity Director will address concerns of residents in monthly resident council meeting. She will also interview residents monthly to ensure their rights are being upheld.

Reporting to the HCPR rule will be followed per rules and regulations.

New policy has been implemented for anyone who has witnessed a situation. They must fill out the new grievance paperwork and give it to supervisor, RCC or BOM.

See attached Grievance form.

Stand up meetings and monthly meeting will be held by Administration, BOM, and RCC to ensure policies and procedures are being followed per rule.

Corrected 12/23/2019

Tag 358 10A NCAC 13F .1004. (a) Medication Administration

POP implemented on 11/22/19. It was applied.

All MA staff received a Diabetic Training class on 11/25/19. All MA staff completed their CEU's on Relias online training.

They had a completion due date of 12/31/19 per rule to be in compliance with state rules and regulations.

New Administrator hired on 12/21/19.

New BOM hired on 01/13/20.

Orders for coumadin on patient #6.

All directions were followed per PCP's orders. All orders were immediately audited against EMAR orders system to ensure accuracy by RCC and BOM. Pharmacist audit was done on 11/25/19 to ensure all orders were accurate.

RCC and BOM will ensure all orders are sent and received by pharmacy.

Refer to Tag 367 for New Medication Policies

BOM, RCC, Administrator and a designee will follow new policy going forward.

Corrected on 12/25/19.

Tag 366 10A 13F .1004 (i) Medication Administration

POP implemented on 11/22/19. It was applied.

Please see attached documentation in relation to Resident # 6 and # 8, from Pharmacy and PCP.

Please refer to Tag 164 ,276, 119, 338, 367 and 358 respectively.

Corrected on 12/25/19

Tag 367 .1004 (j) Medication Administration

POP implemented on 11/22/19. It was applied.

All MA staff were trained on how to document standing ordered medications on the EMAR to ensure accuracy and safety.

All MA staff received a Diabetic Training class on 11/25/19. All MA staff completed their CEU's on Relias online training.

Administrative and Supervisory Staff will:

Review Daily Summary Report on QuickMar to monitor staff behavior.

Utilize Recent Order Profile Changes report on QuickMar to monitor staff behavior.

Utilize Medication Pass Details report on QuickMar to monitor staff behavior.

Utilize Medication Cart Audit report to conduct med cart audits routinely.

Procedure created to process all new orders.

Procedure created to file all orders in a timely manner.

Plan of Correction Action Plan for Medication Administration:

Bullets 1-3 to be completed for 6 months and continued quarterly

1.Facility medication audit weekly (1 cart per week).

2.Pharmacy will complete monthly cart audit to review staff audits and provide a report.

3.Pharmacy will complete monthly medication pass with medication techs and provide a report.

4.All medication staff will retake eMAR training by the end of January 2020.

5.Any new staff will take eMAR training prior to administering medication unsupervised.

6.Any new staff will take diabetes training within 30 days of hire.

Please refer to Tag 164 ,276, 119, 338, and 358 respectively.

Corrected on 12/25/19

Tag 438 10A NCAC 13F .1205

New Administrator hired on December 21st. Assistant Administrator to attend NCALA's AIT Program in February. Immediately reviewed all staff with any allegations or write ups for misconduct, abuse, and neglect accusations. Staff have been relieved of duty.

BOM trained in how and when to do a 24 hour and 5 day report to HCPR per rules and regulations and company policy. 24 hour report was completed. DSS, HC Sheriff Department, PCP and family members all notified of allegations. This investigation is ongoing and pending outcome.

All staff attended a Resident's Rights in service by Intrepid on 12/3/19. All staff to notify supervisors, BOM or RCC of any allegations of abuse or neglect by a resident, their family, staff and visitors.

New policy has been implemented for anyone who has witnessed an incident. They must fill out an incident report after the situation has been assessed by a supervisor. The new grievance paperwork and give it to supervisor, also document on hot spot which is checked daily by RCC or BOM.

See attached Grievance form.

Stand up meetings will be held as needed a weekly meeting will be held for the first 90 days and monthly thereafter by BOM, RCC and designee to ensure policies and procedures are being followed per rule.

Corrected on 12/23/19

Tag 980 GS 131D Implementation

New Administrator hired on 12/21/19.

New BOM hired on 01/13/20.

Refer to tag 119

Refer to tag 164

Refer to tag 165

Refer to tag 271

Refer to tag 276

Refer to tag 282

Refer to tag 316

Refer to tag 338

Refer to tag 358

Refer to tag 366

Refer to tag 367

Refer to tag 438

Refer to tag 451

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D 119	Continued From page 1 -She asked Resident #6 if he wanted to sit down and he stated, "it would be nice." -The MA found a chair for Resident #6 in the living room located next to the medication cart. -The MA helped Resident #6 sit down and she administered one nitroglycerin tablet. Interview with Resident #6 on 11/21/19 at 9:40am revealed: -He did not think "things were going well" for him at the facility. -He had fallen around five times in the last three months. -He recently fell between the two beds in his room, hit his head and separated his right shoulder. -One night he tripped on the wheel on the bed and fell hitting his face on the floor, "I messed up my nose". -The staff made rounds and checked on him around twice per shift. -It took facility staff a long time to respond when he had to "yell for help" because he did not have a call system to call staff for assistance. -He had gone to the hospital for medical evaluation for two falls, two falls the third shift MA talked him into not going to the hospital for medical evaluation, and one fall he crawled on the floor and was able to pull himself up onto the bed. Observation of the women's bathroom on 11/20/19 at 9:23am and the men's bathroom on 11/21/19 at 3:58pm revealed there was not an operative call bell system in the women's bathroom. Observation of the residents' room located on the women's hall revealed: -There was not an operative electrical call bell	D 119		

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D 119	Continued From page 2 system in the bedroom. -There was not free-standing bells located on the night stands or placed reachable to the residents. -Interview with a resident on 11/20/19 at 9:55am revealed: -There was not a call bell system in their room. -She goes to the door and "holler help". -Staff sometimes responds to her calls. Interview with a second resident on 11/20/19 at 10:07am revealed: -She had a free-standing bell in her room. -She kept the free-standing bell on the night stand. -She had moved the bell and could not locate the bell. Interview with a third resident on 11/20/19 at 10:16am revealed: -She had been a resident for three years. -She had never had a free-standing bell in her room. -She "called out" for assistance when she needed help. Interview with a fourth resident on 11/2019 at 10:23am revealed: -She had been a resident for seven years. -There had not been a call system in her room. -There had not been a free-standing bell placed in her room. -She used her cellular phone to call staff when she needed assistance. Interview with a fifth resident on 11/22/19 at 9:40am revealed: -The facility had not provided a way for him to call out for assistance when needed. -He had fallen around five times in the past three	D 119		

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D 119	Continued From page 3 months. -He recently fell between the two beds in his room, hit his head, seperated his shoulder, and had no way to call staff to help him get up off of the floor. His roommate had to find staff to assist him off the floor before he was sent to the hospital for evaluation. -He had chest pain on 11/21/19 and had to walk to the nurses station to report his chest pain to the Medication Aide . -Staff made rounds and checked on him usually twice per shift. -It took staff "a long time" to respond when he would "yell for help". -He had his cell phone in his pocket when he fell once, and used his cell phone to call 911 when he could not get the attention of staff. -Another time he fell and was able to crawl on the floor and pull himself up onto the bed. -He wanted a call system provided to him by the facility so he could get assistance from the staff when needed. Interview with the Business Office Manager (BOM) on 11/20/19 at 3:40pm revealed: -She did not know an operational call system was required for the residents. -Residents with a physician's order for a call bell were provided with a free-standing bell. -There were only two residents with free-standing bells in their rooms. -The bells were placed by the residents' bed side. -Some residents did not have the free-standing bells because they miss used the bells. -Residents were given the option to have a free-standing bell to be placed by their bed side but they declined in having the bell. Interview with the Assistant Administrator (AA) on	D 119		

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D 119	Continued From page 4 11/20/19 at 3:38 pm revealed: -He did not know that an operational call system was required for the residents. -Free-standing bells had been purchased for all residents and placed in their rooms. -The bells were removed because residents abused the bells and would call the facility staff to bring them coffee. -The residents were required to have a physician's order for a call bell and a free-standing bell was given to only those specific residents. -The facility had two residents with a physician's order for a call bell. -He did not know that a call system for the residents was required.	D 119		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;	D 164		

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D 164	Continued From page 5 for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled Medication Aides (Staff B and C) who administered insulin to residents completed training on the care of diabetic residents prior to the administration of insulin. The findings are: 1. Review of Staff B's, Medication Aide (MA), personnel record revealed: -Staff B was hired on 10/14/19. -There was no documentation of training on the care of diabetic residents. -The 15-hour Medication Training was completed on 09/20/19. -The Medication Clinical Skills Checklist was completed on 10/13/19. Review of a residents electronic Medication Administration Record (eMAR) for October 2019 revealed: -Staff B documented she had administered insulin injections on 10/20/19, 10/21/19, 10/24/19,	D 164		

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and 10/29/19 at 7:00am.
-Staff B documented she had administered an insulin injection on 10/24/19 at 10:45am.
-Staff B documented she had administered insulin injections on 10/18/19, 10/26/19, and 10/27/19 at 3:45pm and 8:00pm.

Review of a residents eMAR for November 2019 revealed:
- Staff B documented she had administered insulin injections on 11/09/19 at 7:00am and 10:45am.
- Staff B documented she had administered insulin injections on 11/01/19, 11/05/19, 11/06/19, 11/14/19, 11/15/19, and 11/19/19 at 3:45pm and 8:00pm.

Attempted telephone interview with the facility's contracted Licensed Health Professional Support (LHPS) nurse on 11/21/19 at 10:24am was unsuccessful.

Attempted telephone interview with Staff B on 11/21/19 at 10:26am was unsuccessful.

Refer to the interview with the Business Office Manager (BOM) on 11/21/19 at 9:15am.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/21/19 at 9:38am.

Refer to the interview with a pharmacist from the facility's contracted pharmacy 11/21/19 at 4:55pm.

Refer to the interview with the Assistant Administrator (AA) 11/21/19 at 2:58pm.

Refer to the review of the facility's Pharmaceutical Policy and Procedure Manual.

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2. Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C was hired on 05/01/19.
-There was no documentation that Staff C had received training on the care of diabetic residents.
-The 15-hour Medication Training was completed on 05/21/19.
-The Medication Clinical Skills Checklist was completed on 05/21/19.

Review of a residents electronice Medication Adminstration Record (eMAR) for October 2019 revealed:
-Staff C documented she had administered insulin injections on 10/26/19 and 10/27/19 at 7:00am.
-Staff C documented she had administered an insulin injection on 10/27/19 at 10:45am.
-Staff C documented she had administered insulin injections on 10/03/19, 10/13/19, 10/22/19, and 10/23/19 at 3:45pm and 8:00pm.

Review of a residents eMAR for November 2019 revealed:
-Staff C documented she had administered insulin injections on 11/10/19 at 7:00am, 10:45am and 3:45pm.
-Staff C documented she had administered insulin injections on 11/09/19, 11/10/19, and 11/18/19 at 8:00pm.

Attempted telephone interview with the facility's contracted LHPS nurse on 11/21/19 at 10:24am was unsuccessful.

Telephone interview with Staff C on 11/21/19 at 10:30am revealed:
-She was working at the facility as a Personal Care Aide (PCA) and MA "in training".

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D 164	Continued From page 8 -She thought she had received training on the care of diabetic residents but could not remember when she had received the training or who taught it. -She administered medications and insulin injections to residents while supervised by another MA. -She had not passed the MA examination but had rescheduled to retake the examination. -She had completed her 15-hour MA training and Medication Clinical Skills Checklist in May 2019. Refer to the interview with the Business Office Manager (BOM) on 11/21/19 at 9:15am. Refer to the interview with the Resident Care Coordinator (RCC) on 11/21/19 at 9:38am. Refer to the interview with a pharmacist from the facility's contracted pharmacy 11/21/19 at 4:55pm. Refer to the interview with the Assistant Administrator (AA) 11/21/19 at 2:58pm. Refer to the review of the facility's Pharmaceutical Policy and Procedure Manual. ____________________ Interview with the Business Office Manager (BOM) on 11/21/19 at 9:15am revealed: -She and the RCC were responsible for scheduling the training needed for employees either by online training, with the pharmacy, or with the facility's contracted LHPS nurse. -She thought diabetic training was "covered" by the 15-hour medication training. -She did not know Staff B and Staff C had not completed their diabetic care training. -Staff B and C had administered insulin injections to residents.	D 164		

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JOHNSON BETTER CARE FACILITY, INC.	HWY 301 NORTH DUNN, NC 28335

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D 164	Continued From page 9 -She was responsible for auditing personnel records "ever so often" for expired and/or completed training. -The diabetic care training for MA's was provided as an online course. Interview with the Resident Care Coordinator (RCC) on 11/21/19 at 9:38am revealed: -Either she or the BOM scheduled new employees for their required training. -The facility's contracted pharmacy provided the diabetic care training. -The BOM was responsible for auditing personnel records for expired and/or completed training. -Staff B and C had administered insulin injections to residents. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/21/19 at 4:55pm revealed: -The nurse or a pharmacist from the pharmacy completes the diabetic training for the facility. -The training was available either online, at the pharmacy, or at the facility. -The training was included during the 15 hour medication aide training completed either at the pharmacy or in the facility. -The training included reviewing hypoglycemia, hyperglycemia, sliding scale insulin, and insulin administration Interview with the Assistant Administrator (AA) on 11/21/19 at 2:58pm revealed: -He was responsible for the daily operations of the facility. -He did not know that Staff B and Staff C had not completed their diabetic care training. -The RCC and BOM were responsible for scheduling required training for staff. -He knew that Staff B and Staff C had	D 164		

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D 164	Continued From page 10 administered insulin to diabetic residents. -His expectation was for all personnel records to be monitored and updated with current training documentation. Review of the facility's Pharmaceutical Policy and Procedure Manual revealed: - "Training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin". -"Unlicensed staff may not administer insulin or other subcutaneous injections prior to meeting the requirements for training and competency validation." ______ The facility failed to ensure all medications aides received training on the care of diabetic residents before administering insulin. This failure placed all diabetic residents at risk of incorrect dosing and was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. ______ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 11/22/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 9, 2019.	D 164		
D 165	10A NCAC 13F .0506 Training On Physical Restraints 10A NCAC 13F .0506 Training On Physical Restraints (a) An adult care home shall assure that all staff responsible for caring for residents with medical	D 165		

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symptoms that warrant restraints are trained on the use of alternatives to physical restraint use and on the care of residents who are physically restrained.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to provide physical restraint training for 3 of 4 staff sampled (Staff A, B, and C) who provided care to two residents with orders for physical restraints.

The findings are:

Observation of a resident in room #15 on 11/20/19 at 10:33am revealed:
-A resident was lying in bed on her back with her head of bed elevated.
-There was a bedrail pulled up into a raised position on the right side of the bed.
-The bedrail on the left side of the bed was in a lowered position.
-There was a walker located at the top right side of the bed.

Interview with the resident on 11/20/19 at 10:33am revealed:
-The resident did not have any issues with falling out of bed.
-The bedrail was used to prevent any falls out of the bed.
-She climbed around the bedrail to get out of bed.

Interview with the Business Office Manager (BOM) on 11/21/19 at 9:15am revealed:
-Bedrails were used as a restraint for one resident to keep them from falling out of bed, and a lap belt was used as a restraint for another resident to keep them from falling out of the

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D 165	Continued From page 12 wheelchair. -There was no documentation that Staff A, B, and C had received training for the use of physical restraints. -She did not answer why training had not been completed. -She was responsible for scheduling new employees for their required training. -The Resident Care Coordinator (RCC) and herself were responsible for monitoring personnel records "ever-so-often" to make sure employee training has been completed. Interview with the Resident Care Coordinator (RCC) on 11/21/19 at 9:38am revealed: -The facility had two residents with physician orders for restraints. -Either herself or the BOM were responsible for scheduling employees for required training. -Restraint training was taught by the facility's contracted nurse. -Staff A, B, and C had not received training on the use of physical restraints. -Staff A, B, and C had not been scheduled for a restraint training class. -The BOM was responsible for monitoring personnel records to make sure all training required was completed. Telephone interview with a MA/Personal Care Aide (PCA) on 11/21/19 at 10:30am revealed: -She thought she had received training on the use of physical restraints within the "last couple of months". -She did not know why there was no documentation in her personnel record for the use of physical restraints. Interview with a PCA on 11/22/19 at 11:00am revealed:	D 165		

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D 165	Continued From page 13 -She had not received training on the use of physical restraints. -The staff used bedrails on one residents bed to keep her from falling out of bed. -The staff used a lap belt for another resident to keep them from falling out of the wheelchair. Interview with the Assistant Administrator (AA) on 11/21/19 at 2:58pm revealed: -The physician had ordered physical restraints for two residents at the facility. -The facility used physical restraints for a resident to keep her from falling out of bed, and for another resident to keep him from falling out of the wheelchair. -He did not know Staff A, B, and C had not received training on the use of physical restraints. -The RCC and BOM were responsible for monitoring personnel records to make sure required training was completed by each employee. -The facility had a high employee turn-over rate and it was difficult to get all the staff trained. -His expectation was for all personnel records to be monitored and updated with current training documentation.	D 165		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.	D 271		

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D 271	Continued From page 14 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to respond to an incident in accordance with the facility's established policy and procedures for 1 of 2 sampled residents (Resident #6) as evidenced by the resident (#6) was unable to get assistance from staff after a fall and he had to use his cell phone to call Emergency Medical Services for help. The findings are: Review of the facility's Falls Management Program revealed: -It was the policy of the facility for residents to be monitored and identified for risk of falls. -Fall Risk Assessments were completed for all residents admitted to the facility. -Staff would receive training on Fall Prevention Awareness. -Staff would respond immediately to a resident with a fall and would assess the resident for injury. -Emergency Medical Services (EMS) would be called to transport the resident with an injury from a fall, to the hospital for a medical evaluation. -PCAs notified the MA or RCC immediately of the fall. -PCAs who had witnessed a fall or had found a resident lying on the floor, did not move the resident. -Residents vital signs were taken when a fall had occurred. - Residents who refused medical treatment after a fall occurred were monitored closely for changes in medical condition or behavior.	D 271		

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-The residents Primary Care Physician (PCP) was notified when a fall occurred, and a follow up appointment was scheduled.
-Staff would complete an incident report in its entirety for any fall.
-An assessment would be completed to determine the cause of the fall.
-Staff would complete the 72 Hour Follow Up on resident falls to investigate possible circumstances contributing to the fall and would document observations of the resident for 72 hours after the fall.

Review of Resident #6's current FL2 dated 10/21/19 revealed diagnoses included cerebral infarction, chronic kidney disease, and gastroesophageal reflux disease (GERD).

Observation of Resident #6 on 11/20/19 at 10:20am revealed:
-He was in his room walking from the bed to a chair with a gait belt around his waist and a woman (who identified herself as a Physical Therapist) holding onto the gait belt.
-He had an unsteady gait.
-He was wearing a sling on his right arm.

Interview with Resident #6 on 11/21/19 at 9:40am revealed:
-He did not think "things were going well" for him at the facility.
-He fell recently and could not get assistance from staff to help him off the floor so he used his cell phone to call "911" and the medication aide (MA) got "mad" at him and told him, "you aren't supposed to call 911".
-He did not have a call system in his room to call staff for assistance and it took staff a long time to respond when he had to "yell for help".
-He had fallen five times in the last three months.

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-He once fell between the two beds in his room, hit his head and separated his right shoulder breaking the right clavicle bone.
-One night he tripped on the wheel on the bed and fell hitting his face on the floor, "I messed up my nose". His sister said he should have gone to the hospital for medical evaluation since he took Coumadin (a medication used to treat and prevent blood clots by thinning the blood), but the third shift Medication Aide (MA) did not think he needed to go and said, "I don't like sending people to the hospital on my shift, it's too much paperwork".
-The staff made rounds and checked on him around twice per shift.
-He had gone to the hospital for medical evaluation for two falls, two falls the third shift MA talked him into not going to the hospital for medical evaluation, and one fall he crawled on the floor and was able to pull himself up onto the bed.
-He did not like the way staff treated him.

Attempted telephone interview with the MA on 11/21/19 at 10:26am was unsuccessful.

Interview with a first shift personal care aide (PCA) on 11/22/19 at 11:00am revealed:
-She was not working when Resident #6 fell and hit his head and separated his right shoulder.
-The residents that need help will walk to the nurses station and the residents that are unable to walk to the nurses station will "yell".
-She made rounds and checked on residents every 2 hours unless a resident was a higher level of care and then she rounded on them every 30 minutes.
-When a resident fell, she would report it to the MA or the Business Office Manager (BOM).
-The MA was responsible for calling for an

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ambulance and sending the resident to the hospital for medical evaluation unless the resident refused to go.

Observation of a resident on 11/22/19 at 5:00pm:
-A muffled yell was coming from a resident's room located across from the nurse's desk.
-The resident was yelling for help but his voice could barely be heard in the hallway outside his room.
-The Personal Care Aide (PCA) opened the resident's door after being prompted.
-The resident said he was trying to transfer from his wheelchair to the bed and had fallen onto the bed with his face pressed into the mattress and needed assistance.

Observation of another resident on 11/22/19 at 5:01pm revealed:
-The resident was calling out with a raised voice "hey, I need some help" to the survey team.
-She was standing in the doorway of her room down the hall wearing pants that were visibly wet.
-She stated, "I need some help changing, I'm wet".
-The PCA was sitting at the nurses station and was told the resident needed her assistance.

Interview with a second MA on 11/22/19 at 10:57am revealed:
-She was not working when resident #6 fell.
-There was a fall policy in effect.
-PCAs notified the MA or RCC immediately of the fall.
-PCAs who had witnessed a fall or had found a resident lying on the floor, did not move the resident.
-Residents were checked for injuries and their vital signs were taken when a fall had occurred.
- Residents who refused medical treatment after

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D 271	Continued From page 18 a fall occurred were monitored closely for changes in medical condition or behavior. -Residents who used assistive devices were encouraged to use the devices. -Staff walked along side of residents that required additional assistance with mobility. -The first shift was scheduled with one MA and two Personal Care Aides. Interview with the Resident Care Coordinator on11/22/19 at 11:12am revealed: -There was a fall policy into place. -Residents who had consistent falls, their PCP and/or Psychiatrist were contacted, and a follow up appointment was scheduled. -When a resident had a fall, the staff who had reached the resident first assessed the resident to see if they had been hurt from the fall. -The paramedics were called if the resident had sustained an injury. -Residents who had refused medical assistance, a follow up appointment was made with their PCP. -Residents vital signs were checked. -Residents or other residents who had witnessed the fall yelled out for help if staff were did not witness the fall. -The RCC completed a fall risk assessment on Residents when there was a history of falls. -There were at least eight residents who had been fall risks. -Incident reports were completed for residents who had fallen. -Residents were reminded and encouraged to use their assistive devices. -The shifts were properly staffed to monitor residents who were fall risks. Interview with the Resident Care Coordinator (RCC) on 11/22/19 at 11:59am revealed:	D 271		

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D 271	Continued From page 19 -She did not know Resident #6 had to call EMS because he could not get the attention of staff after he fell. -Incident reports were filed in a notebook at the nurses station. -There were two incident reports for Resident #6 dated 10/20/19 and 10/21/19. -Resident #6 had fallen in his room on 10/18/19 and broke his right clavicle. -She did not know why the MA on duty did not fill out an incident report for Resident #6 when he fell. -The MA would give the incident report to the BOM and she would fax it to the local Department of Social Services (DSS). -The BOM would give her the incident report and she would file it into the notebook they kept at the nurses station for Incident and Accident Reports. Interview with the BOM on 11/22/19 at 11:14am revealed: -The PCA reports to the MA and "me" when a resident fell. -She or the MA would call 911 or the residents attending physician and send the resident to the hospital for medical evaluation if the resident was injured. -The MA notified the family when a resident had an accident and would fill out an incident report. -She did not have any incident reports for Resident #6 that were not filed in the Incident and Accident Report notebook. -She did not know why the MA on duty when Resident #6 fell did not fill out an incident report. Interview with the Assistant Administrator (AA) on 11/22/19 at 11:45am revealed: -The residents get help from staff when they need it. -He did not know why staff did not respond to	D 271		

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D 271	Continued From page 20 Resident #6 when he fell, "yelled for help", and had to use his cell phone to call EMS for help. -The staff make rounds every 15 to 30 minutes. -The residents go to bed around 6:00pm or 7:00pm and staff performed a "head count" every 30 minutes and the MA would record "rounds completed every 30 minutes" in the nurses notes. -The MA was responsible for filling out incident reports and giving them to the BOM. -The BOM and RCC were responsible for faxing Incident reports to the local DSS and filed them into a notebook. -He was not aware an Incident report was not filled out for Resident #6. -He expected staff to follow the facility's policies and procedures for falls.	D 271		
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: TYPE B VIOLATION	D 276		

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Based on observations, interviews, and record reviews, the facility failed to ensure the implementation of physician's orders for 2 of 5 sampled residents for administering a medication to cleanse the bowels for a colonoscopy procedure (Resident #1) and applying a lymphedema intermittent pneumatic compression pump (a device used to treat leg swelling by inflating sleeves that squeeze the legs to promote blood flow to prevent blood clots) (Resident #3).

The findings are;

1. Review of Resident #1's current FL2 dated 08/26/19 revealed diagnoses included dementia with behaviors, seizure disorder, and a history of myocardial infarction, cerebrovascular accident, and brain aneurysm.

Observation on 11/20/19 at 9:40am revealed there was a 6-ounce bottle of Suprep bowel prep (a medication used to cleanse the bowels before having a colonoscopy) sitting on the night stand.

Interview with Resident #1 on 11/20/19 at 9:40am revealed:
-He was going to have a colonoscopy procedure at 11:40am.
-The second shift medication aide (MA) on 11/19/19 gave him the first 6-ounce bottle of Suprep mixed into water to drink at 8:00pm.
-The third shift MA brought him the second 6-ounce bottle of Suprep around 6:00am and said, "drink up". She left the bottle of Suprep with him and he had taken a couple of sips, but he did not like drinking it because it made him "run to the bathroom".

Observation of Resident #1's room on 11/20/19 at

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D 276	Continued From page 22 11:01am revealed: -Resident #1 was not in his room. -The bottle of Suprep, not mixed with water as directed, was sitting on the nightstand and remained at least ¾ full. Review of Resident #1's physician orders dated 11/05/19 revealed an order for Suprep bowel prep kit mix one 6-ounce bottle of Suprep add cool drinking water to 16-ounce line and mix. Drink all the liquid and then drink 2 more 16-ounce containers of water over the next 1 hour before bed on 11/19/19. Mix the second 6-ounce bottle of Suprep add cool drinking water to 16-ounce line and mix. Drink all the liquid and then drink 2 more 16-ounce containers of water at least 2 hours before colonoscopy. Review of Resident #1's electronic Medication Administration Record (eMAR) for November 2019 revealed: -There was a computer-generated entry for Suprep bowel prep kit mix one 6-ounce bottle of suprep add cool drinking water to 16-ounce line and mix. Drink all the liquid. Drink 2 more 16-ounce containers of water over the next 1 hour before bed. -The second shift MA documented the Suprep as administered on 11/19/19 at 8:00pm. -There was no documentation the second 6-ounce bottle of Suprep was administered on 11/20/19. Interview with the Resident Care Coordinator (RCC) on 11/20/19 at 11:06am revealed: -She did not know where Resident #1 was, "I guess he went to the store". -She did not know why Resident #1 had the bottle of Suprep in his room.	D 276		

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Interview with the Business Office Manager (BOM) on 11/20/19 at 11:08am revealed:
-Resident #1 had been taken to his appointment for a colonoscopy procedure by transport.
-She did not know that Resident #1 had not drank his second bottle of Suprep to prepare for the colonoscopy procedure.
-The MA's were not supposed to leave medications with residents.
-She expected the MA's to follow the facility's policies and procedures for administering medications.

Interview with the BOM on 11/20/19 at 11:26am revealed the MA should have watched the resident drink the Suprep and then sign the eMAR it was administered.

Attempted telephone interview with a MA on 11/21/19 at 10:26am was unsuccessful.

Telephone interview with Resident #1's physician on 11/21/19 at 10:38am revealed:
-Complications of Resident #1 not receiving all the ordered Suprep bowel prep was poor vision of the colon from an incomplete prep.
-Resident #1's colon was "murky", and they had to use special equipment to clean the area out.

Interview with the Assistant Administrator (AA) on 11/21/19 at 2:58pm revealed he expected staff to follow the medication policies and procedures.

2. Review of Resident #3's current FL2 dated 06/29/19 revealed:
-Diagnoses included hyperlipidemia, hypertension, major depressive disorder, anxiety, osteoarthritis, and schizophrenia.

Review of Resident #3's physician's orders dated

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D 276	Continued From page 24 08/12/19 revealed a physician's order to activate lymphedema intermittent pneumatic compression pump (lymphedema pump) twice daily as needed (in the morning and evening) for one hour at a time (a device used to treat leg swelling by inflating sleeves that squeeze the legs to promote blood flow to prevent blood clots). Review of Resident #3's September, October, and November 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry to activate lymphedema pump twice daily as needed (in the morning and evening) for one hour at a time scheduled to administer as needed. -There was no documentation the lymphedema pump had been applied. Interview with Resident #3 on 11/20/19 at 9:58am revealed: -He had to keep his legs elevated to keep the fluid from gathering in his lower legs. -He needed to use the pump because his legs were swelling but he needed help to get the pump on his legs while he was sitting in the wheelchair. -He did not need help to apply the sleeves until recently because he was controlling the swelling by elevating his legs in a recliner. -He could not sit or sleep on his bed because it would cause him to have back pain. Observation during initial tour of facility on 11/20/19 at 9:50am revealed: -Resident #3 was sitting in a wheelchair in his room with his feet on the ground. -His lower legs were swollen and extended outward over the edge of his shoes. -The housekeeper came by his room and he had asked for to help him apply the lymphedema pump to his legs.	D 276		

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-She told him she was not working as a personal care aide (PCA) and would need to get someone to help him.
-She walked down the hallway and went into another resident's room where a PCA was working.

Observations throughout the day on 11/20/19 at 11:15am, 1:30pm, 3:00pm, and 4:30pm revealed the lymphedema pump was on Resident #3's bed and no facility staff assisted the resident with the lymphedema pump.

Interview with a PCA on 11/25/19 at 12:02pm revealed:
-She had never helped Resident #3 with the lymphedema pump.
-She knew he had the pump in his room, but he would put it on himself.
-His left leg was swollen last Friday (11/22/19) when she gave him his bath.
-She did not know Resident #3 needed help applying the lymphedema pump.

Interview with a medication aide (MA) on 11/22/19 at 9:52am revealed:
-Resident#3's lymphedema pump was scheduled as needed.
-She had helped him apply the pump to his legs several months ago.
-She did not document when Resident #3 used the pump on his legs.
-He would not tell the staff when he used the pump.

Interview with the Resident Care Coordinator (RCC) on 11/25/19 at 12:05 revealed:
-The MAs or the PCAs were responsible for helping Resident #3 with the lymphedema pump.
-The MAs were not responsible for documenting

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when Resident #3 used the pump.
-She or the MAs had never documented information about the use of the pump on the eMAR.
-Resident #3 needed help to get the lymphedema pump on his legs because he was a "large man" and it would be hard for him to bend over and put them on correctly.

Telephone interview with Resident #3's primary contact on 11/25/19 at 1:05pm revealed:
-He was a physician assistant at a local wound clinic that previously followed Resident #3.
-He followed Resident #3 at the wound clinic last year because he had a lower extremity ulcer on his leg.
-He had written the order for the lymphedema pump and transferred the care of the pump to Resident #3's Primary Care Provider (PCP) after he was discharged from the wound clinic.
-Resident #3 needed to wear the lymphedema pump to control the edema (fluid) in his lower legs prevent a blood clot or a diabetic ulcer from reoccurring on his legs.
-The lymphedema pump was important to improve the circulation in Resident #3's lower legs and prevent future diabetic ulcers.
-Resident #3 was at an increased developing a diabetic ulcer if the lymphedema pump was not applied when edema started developing in his lower legs.

Telephone interview with Resident #3's Primary Care Provider (PCP) on 11/25/19 at 9:45am revealed:
-Resident #3's lymphedema had been well controlled because he kept his feet elevated in a recliner in his room and he was able to ambulate around the facility.
-It was important for Resident #3 to keep his legs

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elevated to keep the swelling controlled.
-She did not know the recliner was removed from Resident #3's room.
-Resident #3 had poor circulation in his lower legs and needed the pump to prevent blood clots by improving the circulation in his legs.
-Resident #3 was at an increased risk of a deep vein thrombosis (DVT) if his lymphedema continued to be uncontrolled.

Interview with the Assistant Administrator (AA) on 11/22/19 at 12:20pm revealed:
-The recliner was removed from Resident #3's room because it was dirty, and the resident would not let the facility staff clean the recliner.
-He did not realize the recliner was needed to help control Resident #3's swelling his legs.
-The RCC and the BOM was responsible for making sure the PCAs and MAs were following all physician's orders in the facility.
-The facility staff should be assisting Resident #3 with the lymphedema pump.

Interview with the Administrator on 11/21/19 at 3:00pm revealed the AA was responsible for the day to day operations at the facility.

____

The facility failed to ensure implementation of an order for administering a medication to cleanse the bowels for a colonoscopy procedure for Resident #1, resulting in the physician having poor vision of the colon from an incomplete bowel prep and having to use specialized equipment on the resident to clean the area out and Resident #3 did not receive assistance with applying a lymphedema intermittent pneumatic compression pump to treat leg swelling after requesting assistance from staff to apply the sleeves resulting in increased lower extremity edema in both legs increasing the risk for developing a

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D 276	Continued From page 28 diabetic ulcer. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. ______________ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 11/22/19. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 9, 2019.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, record review and, interviews, the facility failed to assure the kitchen and food storage areas were clean and free of contamination related to improper storage of the ice scoop and black stains and white substance on the food storage containers and the food containers in the food pantry not dated and labeled. The findings are: Review of the Food Establishment Inspection Report on 11/20/19 at 12:20pm revealed the food service area had been inspected on 09/2019 and received a score of 91.	D 282		

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Observation of the ice maker located in the kitchen on 11/20/19 at 10:35am revealed:
-There were a large silver metal ice scooper and a small blue plastic ice scooper lying on the ice inside of the ice machine.
-The ice machine did not have an ice scooper holder attached to it.
-The Cook removed the silver metal ice scooper from the ice machine.
-A Personal Care Aide (PCA) removed the blue plastic ice scooper from the ice machine and placed it on top of the ice machine.

Observation of the inside pantry located off the kitchen on 11/20/19 at 10:45am revealed:
-There was a blue container with black and brown stains on sides and the lid.
-The blue container was not labeled and dated.
-There was another blue container with packets of hot sauce but was not labeled and dated.
-There was a red container with packets of mustard and was not labeled and dated.
-There was another red contained labeled "grape jelly" but contained mayonnaise packets.
-The red container contained with the mayonnaise packets had black and red stains around the outside of the container and on top of the lid and was not labeled and dated.
-There was a large clear container with a blue lid of loose macaroni noodles but was not labeled.
-There was a large clear container with a clear lid that contained packets of loose spaghetti noodles but was not labeled with date.
-There was a large clear container with a blue lid of loose rice that was not labeled and dated.
-There was another clear container with a red lid of loose rice and container was stained with a white powdery substance.

Interview with the cook on 11/20/19 at 10:57am

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D 282	Continued From page 30 revealed: -The cook had been employed for six months. -She was responsible for prepping and preparing all residents meals and cleaning the kitchen and stocked food. -She did not know that clear containers of food were to be labeled and dated. -She did not know when the food items had been placed in the containers. -Containers were washed and cleaned once the contents were used. -She did not know when the containers had last been washed. -The ice machine did not come with an ice scoop holder. -She did not know the place the ice scoop in its own container. -She did not have a cleaning list. Telephone interview with the lead cook on 11/21/19 at 6:03pm revealed: -She was the supervisor of the kitchen and lead cook. -She had been employed for over twenty years. -She was responsible for ordering food and stocking food. -She did not label the containers. -She cleaned all containers every two days. -She last cleaned the containers on 11/19/19. -She completed general cleaning each day she worked. -She worked on the week days. -She completed a deep cleaning of the kitchen bi-weekly. -She did not have a cleaning schedule. Telephone interview with the County Health Inspector on 11/21/19 at 11:56am revealed: -She completed food inspection on the morning of 11/21/19.	D 282		

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D 282	Continued From page 31 -There were two types of contaminations for storing foods in containers. -Food contact services was removing food from its original packing and placing it in a container. -Non-food contact service was placing the original food packing it in a container. -Containers not properly cleaned and sanitized caused bacteria to travel from the containers to the food via the workers hands. -This type of contamination could cause the spread of E.coli. Interview with the Business Office Manager on 11/20/19 at 10:59am revealed: -She did not know that all clear containers were to be labeled and dated. -The ice machine was new and did not come with an ice scooper holder. -She would use a white container as an ice scooper holder. -The cooks were responsible for cleaning the kitchen and the pantry. -The cooks were responsible for stocking and labeling all food. -There was not a cleaning schedule. Refer to the interview with the Assistant Administrator on 11/21/193:38pm revealed: -He and the lead cook were responsible for ordering the food. -Both cooks were responsible for cleaning the entire kitchen and pantry. -Both cooks were responsible for labeling and dating all food. -Both cooks were responsible for storing all food. -He did not know when the kitchen was last cleaned. -He expected the kitchen to be cleaned daily with a general cleaning. -He did not know the containers of food was not	D 282		

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D 282	Continued From page 32 properly labeled and dated. -He did not know there was not a cleaning schedule.	D 282		
D 316	10A NCAC 13F .0905 (c) Activities Program 10A NCAC 13F .0905 Activities Program (c) The activity director, as required in Rule .0404 of this Subchapter, shall: (1) use information on the residents' interests and capabilities as documented upon admission and updated as needed to arrange for or provide planned individual and group activities for the residents, taking into account the varied interests, capabilities and possible cultural differences of the residents; (2) prepare a monthly calendar of planned group activities which shall be easily readable with large print, posted in a prominent location by the first day of each month, and updated when there are any changes; (3) involve community resources, such as recreational, volunteer, religious, aging and developmentally disabled-associated agencies, to enhance the activities available to residents; (4) evaluate and document the overall effectiveness of the activities program at least every six months with input from the residents to determine what have been the most valued activities and to elicit suggestions of ways to enhance the program; (5) encourage residents to participate in activities; and (6) assure there are adequate supplies, supervision and assistance to enable each resident to participate. Aides and other facility staff may be used to assist with activities.	D 316		

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This Rule is not met as evidenced by:
Based on record review, observations and interviews, the facility failed to assure residents were offered activities designed to promote the residents' active involvement.

The findings are:

Record review of the November 2019 activities calendar posted in the hallway on 11/20/19 at 10:33am revealed:
-On 11/20/19 from 10:00am-11:00am nails was scheduled.
-On 11/20/19 from 1:00pm-2:00pm bingo was scheduled.
-On 11/20/19 from 2:00pm-3:00pm karaoke was scheduled.
-On 11/21/19 from 1:00pm-2:00pm bunco was scheduled.
-On 11/21/19 from 5:00pm-7:00pm movies was scheduled.
-On 11/22/19 from 1:00pm-2:00pm bingo was scheduled.
-On 11/22/19 from 2:00pm-3:00pm store day was scheduled.
-There was 16 hours of activities scheduled for the week of November 17-23, 2019.

Observation on 11/20/19 at 10:34am revealed there was a cabinet in the residents' day room filled with various activity supplies of coloring pencils, colored paper, bingo game, puzzles, board games, etc.

Observations on 11/20/19 at 2:49pm - 3:00pm revealed, the karaoke activity was not being facilitated by staff or conducted as scheduled.

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Observation of the November 2019 activities calendar posted in the hallway on 11/21/19 at 8:30 am revealed:
-There was not a disclaimer noted on the calendar that activities were subjected to be changed or canceled.

Interview with a resident on 11/20/19 at 9:36am revealed:
-Only bingo was offered as the activity on Mondays, Wednesdays and Fridays.
-The outside activity included only shopping.

Interview with a second resident on 11/20/19 at 9:55am revealed:
-Bingo was the only activity which was three times a week.
-There were not any outside activities.
-She had made suggestions to have different activities and no one responded to her suggestion.

Interview with third resident on 11/20/19 at 10:16am revealed:
-Bingo, Bible study and devotion was offered as activities.
-There were different church groups that played different games with the residents.
-Activities were not scheduled daily.

Interview with fourth resident on 11/20/19 at 10:30am revealed:
-Activities were not held daily.
-The church came to the facility and held an activity once a week.
-The residents did not go to eat out at the local fast food restaurants.

Interview with Resident Care Coordinator (RCC) on 11/21/19 at 4:35pm revealed:

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-She was the Activities Director.
-The monthly activities calendar had at least fourteen hours of scheduled activities weekly.
-She delegated facilitating the activities to other staff when she was busy.
-There were seven or eight organizations that facilitated activities.
-Residents made suggestions for other having other activities including movie night offsite.
-Offsite activities were hard to schedule because of transportation issues.
-Residents did go to the store at least once a monthly and other times were per their requests.
-Activities were sometimes substituted for another activity if a scheduled activity was not held.
-She not facilitate the karaoke activity on 11/20/19 because she was busy or delegate this to another staff.
-She did not ask another staff to facilitate the karaoke activity on 11/20/19.
-Sometimes she had other important work to do and would not facilitate an activity.

Interview with the Business Office Manager (BOM) on 11/21/19 at 4:00pm revealed:
-The RCC was also the Activities Director.
-The Transportation Coordinator transported the residents to outside activities.
-She had not monitored any activities.
-Activities were held daily.
-She did not know how hours were scheduled for weekly activities.
-Some residents had made suggestions to change and add activities and some of the changes were received.
-She did not remember any of the activity suggestions.

Interview with the Assistant Administrator on

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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

(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 316 — Continued From page 36 — D 316

11/21/19 at 4:00pm revealed:
-The RCC is the Activities Director.
-He did not supervise any activities.
-He recently purchased $500 in supplies just for activities.

D 338 — 10A NCAC 13F .0909 Resident Rights — D 338

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:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to assure 7 of 15 residents were free of neglect and physical abuse related to Resident #12 being physically abused after an altercation with Staff A, Resident #4 not being treated with respect and dignity related to incontinence care, staff cussing and being disrespectful to multiple residents (Resident #4, #5, #11, #13, and #15), and being afraid to voice a concern due to retaliation by the staff (Resident #3).

The findings are:

1. Review of Resident #12's current FL2 dated 09/25/19 revealed diagnoses included insomnia, bipolar, diabetes, and hypertension.

Interview with Resident #12 on 11/22/19 at 2:00pm revealed:
-"That girl tried to turn" his arm.
-"That girl hurt my arm."

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D 338	Continued From page 37 -"That girl person twisted" his neck and his "Adam's apple." -He did not remember when the incident occurred, but stated it happened "a while ago." -He reported the incident to the "Owner". -"The girl" still worked at the facility and had worked on today. -He was taken to the hospital and he told the hospital staff what happened to his arm. Interview with the Personal Care Aide (PCA) on 11/22/19 at 2:47pm revealed: -She noticed a large red bruise on Resident #12 right arm when she reported to work at 5:30am. -The incident occurred about two months ago on third shift. -Resident #12 was crying and said, "Look at what she did to me." -Resident #12 stated that "a girl did it" and pointed out "the girl" as a staff who had bruised his arm. -Resident #12 had fallen later than day around 12:00pm and was taken to the hospital. -The PCA reported the incident to the Assistant Administrator (AA). -The PCA stated the AA was "shocked' and "angry" and that he was going to address the incident. -The staff was a PCA and was still employed. Interview with Medication Aide (MA) on 11/22/19 at 2:08pm revealed: -Resident #12 reported to the MA that a staff member had twisted and bruised his arm. -She noticed there was a red bruise on Resident#12's right arm. -The AA informed the Business Office Manager (BOM) about Resident #12's arm being bruised by staff. -The staff was no longer an employee when she	D 338		

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D 338	Continued From page 38 had learned who the staff was that bruised Resident #12's arm. -She expected all the staff to be respectful and kind to the residents and assist them with all their needs. -Some residents had brought their concerns about the PCAs to her attention. -She always reported those concerns to the BOM. -She supervised the PCA when assigned to her shift. -She reported the incident of the PCA comments to the BOM. -The MA did not know why the incident occurred. -The MA reported the incident to AA. -The MA stated the AA was upset about the incident. -She did not know if the PCA was reprimanded. -The PCA was still employed. Interview with the Resident Care Coordinator (RCC) on 11/22/19 at 10:15am revealed: -Residents had not complained about staff in over three months. -Residents reported their concerns about staff to the BOM because she had a better rapport with them. -Some staff had been suspended for the use of profanity towards the residents. -Residents' complaints were documented. -She was not sure if any residents had brought their concerns the MAs. -She did random checks with residents and asked if they had any issues, concerns or complaints. -She reported all complaints received to the BOM and the AA. -Staff received in-service training on customer service and residents' rights. -The last in-service training was held on 07/18/19.	D 338		

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-In-service trainings were mandatory for all staff.
-She expected staff treat the residents with dignity and respect.

Interview with BOM on 11/22/19 at 3:12pm.
-The PCA had been suspended about one month ago for not giving a resident a shower.
-Resident #12 reported to the MA that a staff member had twisted and bruised his arm.
-The AA informed the BOM about Resident #12's arm being bruised by staff.
-The staff was no longer an employee when she had learned who the staff was that bruised Resident #12's arm.
-Staff had received training relating to residents' rights in July 2019.
-Another in-service training was scheduled for December 2019 on residents' rights.
-She expected all the staff to be respectful and kind to the residents and assist them with all their needs.

Interview with the AA on 11/22/19 at 3:12pm revealed:
-The PCA had been terminated twice but was rehired.
-The PCA had also been suspended previously for her behavior towards residents.
-An anger management in-service training was provided to the staff as it related to residents' rights.
-Staff meetings are held regularly and are mandatory.
-The last staff meeting was held in October 2019 and residents' rights was addressed.
-He did not tolerate staff mistreating residents.

Refer to the interview with the RCC on 11/22/19 at 10:55am.

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D 338	Continued From page 40 2. Review of Resident #4's FL-2 dated 10/21/19 revealed diagnoses included candidiasis of skin and nails, Type 2 diabetes, retention of urine and central pontine myelinolysis. Review of Resident #4's record revealed an admission date of 10/21/19. Interview with Resident #4 on 11/22/19 at 2:29pm revealed: -A Personal Care Aide (PCA) stated to her that, "This is not a nursing home" about three months ago. -The comment was stated because of "my health care needs." -It made her "Feel some kinda way", "hurt" and "mad". -She reported the incident to the Business Office Manager (BOM). Interview with a resident on 11/21/19 at 4:52pm revealed: -She had recently caught three PCA's going through her belongings because they had accused her of smoking in her room. -She did not like asking the PCA's for help because three of them "play mind games with me". -She did not want to eat lunch in the dining room because one PCA was so mean to her. When she would ask for something the PCA would say, "I don't care what you want". -She did not know what she had done to make the PCA hate her. -She felt terrible from the way staff had treated her and she wanted to move to another facility. Interview with a second resident on 11/21/19 at 5:30pm revealed: -He had witnessed staff cursing other residents.	D 338		

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-The PCA's were verbally abusive to residents.
-Staff would yell at residents in the dining room, "hurry up and eat so you can get the hell out of here".
-He did not want any allegations of verbal or mental abuse regarding staff to be discounted.

Interview with a third resident on 11/21/19 at 5:40pm revealed he did not want to be around one of the PCA's due to them cursing all the time.

Interview with the Medication Aide (MA) on 11/21/19 at 4:48pm.
-She was aware of a PCA stating to Resident #4, "This is not a nursing home."
-The PCA also stated to Resident #4, "She needed to start doing for herself."
- Resident #4 informed her of the PCA behavior towards the resident.
-The incident occurred about three months.
-She had received complaints from residents about staff yelling and being "rude" towards the residents.
-She had not witness the PCAs being rude to the residents.
-Had addressed the residents' concern of the PCAs being rude towards the residents.
-She had reported residents' concerns to the BOM and Resident Care Coordinator (RCC).
-She expected the PCAs to treat all residents with respect and to be patient with the residents.

Interview with a second MA on 11/22/19 at 2:08pm revealed:
-Some residents had brought their concerns about the PCAs to her attention.
-She always reported those concerns to the BOM.

Interview with the RCC on 11/22/19 at 10:15am

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D 338	Continued From page 42 revealed: -The Residents had not complained about the PCAs in over three months. -Residents reported their concerns about staff to the BOM because she had a better rapport with them. -Some staff had been suspended for the use of profanity towards the residents. -Residents' complaints are documented. -She was not sure if any residents had brought their concerns the MAs. -She did random checks with residents and asked if they had any issues, concerns or complaints. -She reported all complaints received to the BOM and the Assistant Administrator (AA). -Staff received in-service training on customer service and residents' rights. -The last in-service training was held on 07/18/19. -In-service trainings are mandatory for all staff. -Staff received a written reprimand if they failed to attend the training. -She had not issued any written reprimands to staff relating to violating residents' rights. -She expected staff treat the residents with dignity and respect. Interview with BOM on 11/22/19 at 3:12pm. -Resident #4 reported the issue of the staff stating "This is not a nursing home" to her. -She had verbally addressed the PCA for making the comment to Resident #4. -The PCA was not suspended for this incident. -The PCA had been suspended about one month ago for not giving a resident a shower. -The incident involving Resident #4 was not reported to the Health Care Personnel Registry (HCPR). -Staff had received training relating to residents' rights in July 2019.	D 338		

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D 338	Continued From page 43 -Another in-service training was scheduled for December 2019 on residents' rights. -She expected all the staff to be respectful and kind to the residents and assist them with all their needs. Interview with the AA on 11/22/19 at 3:12pm revealed: -He had been made aware of the "This is not a nursing home" comment to Resident #4. -The incident occurred about three months ago. -The PCA had received a verbal reprimand but was not suspended. -The PCA had been terminated twice but was rehired. -The PCA had also been suspended previously for her behavior towards residents. -The incident involving Resident #4 was not reported to the HCPR. -An anger management in-service training was provided to the staff as it related to residents' rights. -Staff meetings are held regularly and are mandatory. -The last staff meeting was held in October 2019 and residents' rights was addressed. -He did not tolerate staff mistreating residents. -He was upset to learn of the comment made to Resident #4. Refer to the interview with the RCC on 11/22/19 at 10:55am. 3. Review of Resident #3's current FL2 dated 06/29/19 revealed diagnoses included hyperlipidemia, hypertension, major depressive disorder, anxiety, osteoarthritis, and schizophrenia. Interview with Resident #3 on 11/20/19 at 9:58am	D 338		

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revealed:
-If he complained to facility staff, they would deny services to get back at him.
-He did not get anything to drink at dinner one night because he had complained about a medication aide (MA).
-When he asked for a can of soda from the kitchen, the facility staff shook the drink before they gave it to him.

Interview with Resident #3 on 11/21/19 at 10:50am and 4:30pm revealed:
-He had asked the second shift Medication Aide (MA) on 11/15/19 to administer his medication several times and she told him that she was "busy" and would do it later.
-The staff refused to give him soda sometimes from the kitchen refrigerator that he had purchased.
-He was not allowed in the kitchen to get his soda from the refrigerator.
-He felt tormented and got anxious when staff were "mean and retaliate" against him.
-He did not want to live at the facility anymore and wanted to transfer to a different facility.

Interview with a resident on 11/21/19 at 4:40pm revealed:
-Some of the personal care aides (PCA) were "mean".
-Her roommate was more outspoken and would "get into it more" with the PCA's.
-She just "walked around on egg shells".
-She wanted the Resident Council to be restarted so the residents could voice their opinions.
-The facility had not held a functional Resident Council meeting in about a year.

Interview with another resident on 11/20/19 at 9:35am revealed:

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D 338	Continued From page 45	D 338		

Continued From page 45

-The cook refused to give a second serving of food if he complained about the amount of food that was served.
-He had asked maintenence to help fix the drawers on his wardrobe for three months and had been ignored.

Interview with another resident on 11/21/19 at 9:40am revealed:
-He had gone to the hospital for medical evaluation for two falls, two falls the third shift MA talked him into not going to the hospital for medical evaluation, and one fall he crawled on the floor and was able to pull himself up onto the bed.
-He did not like the way staff treated him and was thinking about moving to another facility.
-The cook had an "attitude" and did not treat him with respect and would respond "puppy dog tails" when he asked what they were having for dinner.

Interview with the Assitant Administrator (AA) on 11/22/19 at 5:00pm revealed:
-He did not know the residents did not feel safe from retaliation from the facility staff.
-The entire facility staff recently completed training on resident rights.
-He did not know how to find staff that cared about the residents.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/22/19 at 10:55am.

Refer to Tag 276.

Interview with the Resident Care Coordinator (RCC) on 11/22/19 at 10:15am revealed:
-Residents reported their concerns about staff to the Business Office Manager (BOM) because she had a better rapport with them.

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D 338	Continued From page 46 -Some staff had been suspended for the use of profanity towards the residents. -Residents' complaints are documented. ____________ Based on observations, interviews, and record reviews, the facility failed to assure 7 of 15 residents were free of neglect and physical abuse related to Resident #12 having a bruise on his arm from an altercation with Staff A, multiple residents (Resident #3, #4, #5, #11, #13, and #15) were verbally abused by staff resulting in the residents feeling upset, ignored, and afraid to voice their concerns due to the staff refusing to provide services, including personal care, medications, and dietary. The facility's failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. ____________ The facility provided a plan of protection on 11/22/19 in accordance with G.S. 131D-34 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOTE EXCEED JANUARY 9, 2020.	D 338		
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.	D 358		

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This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a physician for 5 of 13 residents observed during the medication pass (Residents #7, #8, #9, #10, and #11) and 2 of 6 sampled residents (Residents #3 and #6) related to not administering the correct dose of a blood thinner (#6), not administering the correct dose of fast acting insulin (#7, #8), administering pain medication as needed when the medication order was for scheduled dosing (#9), administering the incorrect dose of two medications listed on the standing orders (#10, #11) and not having a shampoo available to help improve healing after having cancer removed from the scalp (#3).

The findings are:

1. The medication error rate was 22% as evidenced by 6 errors out of 27 opportunities observed during the medication pass on 11/20/19 at 10:45am and 4:20pm and 11/21/19 at 10:16am.

a. Review of Resident #8's current FL2 dated 10/07/19 revealed:
-Diagnoses included atrial fibrillation, peripheral vascular disease, dementia, hypertension, and diabetes.
-Novolog Flexpen (a device used to administer insulin) 100units/ml inject 3 units subcutaneously twice daily with lunch and dinner, hold if blood sugar is less than or equal to 110 or if patient doesn't eat a meal (used to treat diabetes).

Review of Resident #8's hospital discharge dated 10/23/19 revealed a medication list for Resident

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#3 that included Novolog Flexpen 100units/ml to inject 4 units subcutaneously three times daily before breakfast, lunch, and dinner, hold if blood sugar is less than or equal to 110 or if patient doesn't eat a meal.

Review of Resident #8's physician's orders dated 11/04/19 revealed a physician's order changing the dose of Novolog Flexpen 100units/ml to inject 10 units subcutaneously three times daily before breakfast, lunch, and dinner, hold if blood sugar is less than or equal to 110 or if patient doesn't eat a meal.

Observation of the medication pass on 11/20/19 at 11:05am revealed the medication aide (MA) administered 12 units of Novolog 100units/ml to Resident #8 after a fingerstick blood sugar (FSBS) of 483.

Review of Resident #8's October 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated order for Novolog Flexpen 100units/ml inject 3 units subcutaneously twice daily before lunch and dinner, hold if blood sugar is less than or equal to 110 or if patient doesn't eat a meal scheduled to administer at 10:45am and 3:45pm.
-Novolog Flexpen 3 units was documented as administered at 10:45am and 3:45pm for 9 of 13 opportunities.
-Resident #8 was administered no insulin on 10/01/19, 10/02/19, 10/04/19, and 10/06/19 at 3:45pm.
-On 10/07/19, FSBS was 423 and 6 units of Novolog was administered.
-There was a computer-generated order for Novolog Flexpen 100units/ml inject 4 units subcutaneously three times daily before

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PRINTED: 12/17/2019
FORM APPROVED

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STREET ADDRESS, CITY, STATE, ZIP CODE: HWY 301 NORTH, DUNN, NC 28335

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D 358	Continued From page 49 breakfast, lunch, and dinner, hold if blood sugar is less than or equal to 110 or if patient doesn't eat a meal scheduled to administer at 6:15am, 10:45am, and 3:45pm. -Novolog Flexpen 4 units was documented as administered at 6:15am, 10:45am, and 3:45pm for 35 of 42 opportunities. -On 10/09/19 at 3:45pm, the FSBS was 143 and no Novolog was administered. -On 10/11/19 at 6:15am, the FSBS was 120 and no Novolog was administered. -On 10/11/19 at 3:45pm, the FSBS was 279 and no Novolog was administered. -On 10/15/19 at 3:45pm, the FSBS was 220 and no Novolog was administered. -On 10/16/19 at 3:45pm, the FSBS was 240 and no Novolog was administered. -On 10/17/19 at 3:45pm, the FSBS was 248 and no Novolog was administered. -On 10/20/19 at 3:45pm, the FSBS was 241 and no Novolog was administered. -Resident #8 was out of the facility in the hospital from 10/22/19 to 11/04/19. Review of Resident #8's November 2019 eMAR revealed: -There was a computer-generated order for Novolog Flexpen 100units/ml inject 10 units subcutaneously three times daily before breakfast, lunch, and dinner, hold if blood sugar is less than or equal to 110 or if patient doesn't eat a meal scheduled to administer at 6:15am, 10:45am, and 3:45pm. -Novolog Flexpen 10 units was documented as administered at 6:15am, 10:45am, and 3:45pm for 45 of 55 opportunities from 11/04/19 to 11/22/19. -Novolog should have been administered 10 times during the month of November but was not administered.	D 358		

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	HAL043003	A. BUILDING: ______ B. WING ______	R 11/25/2019

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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-On 11/07/19 at 3:45pm, the FSBS was 200 and no Novolog was administered.
-On 11/11/19 at 3:45pm, the FSBS was 242 and no Novolog was administered.
-On 11/12/19 at 3:45pm, the FSBS was 180 and no Novolog was administered.
-On 11/13/19 at 3:45pm, the FSBS was 134 and no Novolog was administered.
-On 11/15/19 at 6:15am, the FSBS was 140 and no Novolog was administered.
-On 11/15/19 at 10:45am, the FSBS was 132 and no Novolog was administered.
-On 11/16/19 at 3:45pm, the FSBS was 220 and no Novolog was administered.
-On 11/20/19 at 6:15am, the FSBS was 210 and no Novolog was administered.
-On 11/20/19 at 10:45am, the FSBS was 483 and 12 units of Novolog was administered.
-On 11/21/19 at 3:45pm, the FSBS was 285 and 4 units of Novolog was administered.

Observation of medications on hand for Resident #8 revealed one Novolog Flexpen was available to be administered with 110 units remaining and an expiration date noted as 12/19/19.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/21/19 at 9:38am revealed:
-The pharmacy dispensed 2 Novolog Flexpens to Resident #8 on 10/07/19 with the directions inject 4 units subcutaneously three times daily before meals.
-Each Novolog Flexpen contained 300 units and expired 28 days after first use.
-The pharmacy received a physician's order increasing Novolog Flexpen to 10 units before each meal on 11/04/19 but the medication order was on file and had not been dispensed.

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NAME OF PROVIDER OR SUPPLIER: JOHNSON BETTER CARE FACILITY, INC.

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D 358	Continued From page 51 Interview with the medication aide (MA) on 11/22/19 at 4:41pm revealed: -She did not know why she gave Resident #8 more insulin than the order listed on the eMAR. -She had called the provider because Resident #8's FSBS was over 400 and told the provider how much insulin she had administered. -The provider said to monitor the resident and recheck his FSBS in one hour. -She did not know why she did not administer insulin to Resident #8 during the morning medication pass on 11/20/19. -She did not remember anything about the month of October related to administering insulin to Resident #8. -She administered medications based on the eMAR. Interview with the Business Office Manager (BOM) on 11/21/19 at 8:10am revealed: -She did not know why the MA was not administering insulin as ordered during the medication pass on 11/20/19. -She thinks the MA was confused about the dose of insulin to administer to the residents. Telephone interview with Resident #8's Primary Care Provider (PCP) on 11/25/19 at 9:45am revealed: -Resident #8 had just returned from the hospital following an episode of hyperglycemia. -His FSBS had fluctuated over the past several months. -She did not know the facility was not administering the insulin correctly. -The MA had contacted her regarding Resident #8's elevated FSBS at lunch on 11/20/19. -She did not know Resident #8 did not receive his morning insulin on 11/20/19. -It was important for the facility to administer his	D 358		

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insulin correctly because she was making changes to his insulin dose to control his diabetes.
-Not administering the insulin correctly increases the risk of hyperglycemia which causes dizziness, loss of motor control, and palpitations.
-If Resident #8 continues to have hyperglycemia over an extended period it increases the risk of declining kidney function and macular degeneration (eye condition that can result in losing vision).

Based on observations, interviews, and record reviews, Resident #8 was not interviewable.

Refer to the interview with a MA on 11/22/19 at 9:52am.

Refer to the interview with a second shift MA on 11/21/19 at 4:00pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/21/19 at 4:08pm.

Refer to the interview with the BOM on 11/21/19 at 3:40pm.

Refer to the interview with the Assistant Administrator (AA) on 11/21/19 at 3:00pm.

Refer to the interview with the Administrator on 11/21/19 at 3:00pm.

b. Review of Resident #9's current FL2 dated 03/18/19 revealed diagnoses included rheumatoid arthritis.

Review of Resident #9's physician's order revealed a physician's order dated 10/30/19 for Percocet 10/325mg take 1 tablet four times daily

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D 358	Continued From page 53 (used to treat pain). Observation of the medication pass on 11/20/19 at 4:45pm revealed: -Resident #9 asked for his afternoon medications and was told by the medication aide (MA) he would have to wait for a few minutes. -Resident #9 was leaning against the wall by the medication cart. -Resident #9 stated he could not stand and wait, he would have to come back later. -Resident #9 returned to the medication cart approximately 15 minutes later to take his medications. -The MA administered 2 medications to Resident #9. -Resident #9 did not receive a dose of Percocet 10/325. Review of Resident #9's November 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Percocet 10/325mg take 1 tablet four times daily scheduled as an as needed medication (PRN). -Percocet was documented as administered 32 times as an PRN medication from 11/01/19 to 11/21/19. -Percocet was documented as administered 8 times from 11/12/19 to 11/21/19. Observation of medications on hand for Resident #9 on 11/21/19 at 10:32am revealed: -There were 27 tablets of Percocet 10/325 dispensed on 11/12/19 with the directions take 1 tablet four times daily available to administer. -The Percocet was in color coded cassettes based on administration times. -The cassettes were labeled with a sticker "Directions Changed, Refer to Chart."	D 358		

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D 358	Continued From page 54 -The administration times on the cassettes were 7:00am, 11:00am, 4:00pm, and 11:00pm. Review of Resident #9's Controlled Substance Count Sheet for Percocet 10/325 on 11/21/19 at 4:35pm revealed: -The facility received 56 tablets of Percocet 10/325 for Resident #9 on 11/12/19. -The facility had administered 31 doses of Percocet since 11/12/19 to Resident #9. -The facility had 26 tablets available to administer Interview with Resident #9 on 11/21/19 at 12:54pm revealed: -He was taking two pain medications. -He knew the dose of Percocet had been changed to 1 tablet four times daily on schedule. -He thought he was getting his pain medication as prescribed. -He would ask for it sometimes and the MA would say he had to wait untill it was due. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/21/19 at 9:38am revealed: -The pharmacy filled 120 tablets of Percocet 10/325 for Resident #9 on 10/30/19 with the directions to take 1 tablet four times daily. -The pharmacy delivered 56 tablets of Percocet for Resident #9 to the facility on 10/30/19 and 11/12/19. -She did not know why the administration time on the eMAR was scheduled as needed. -The previous order for Percocet for Resident #9 prior to 10/30/19 had the directions to administer as needed. -She was going to correct the order today (11/21/19). Interview with a MA on 11/21/19 at 4:32pm	D 358		

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D 358	Continued From page 55 revealed she did not give the Percocet because it did not show up on the eMAR to administer to Resident #9. Interview with the Resident Care Coordinator (RCC) on 11/21/19 at 4:08pm revealed: -She had administered medications last week to Resident #9 and his Percocet was "popping" on the eMAR as a scheduled medication. -She did not know how the administration time was changed to as needed. -She did not audit the eMAR after the order was initially entered on the eMAR. Telephone interview with a nurse from Resident #8's pain clinic on 11/22/19 at 4:48pm revealed: -Resident #9 should be administered Percocet four times daily on schedule. -Resident #9 was being followed by the pain clinic for rheumatoid arthritis in his knees and pain related to a partial amputation of his right foot. -Resident #9 reported his was having "severe breakthrough pain" at his last appointment on 10/30/19. -The provider had changed Resident #9's Percocet to scheduled to help control the breakthrough pain. -If Resident #9 did not get his pain medication as prescribed then he would have increased discomfort. Refer to the interview with a MA on 11/22/19 at 9:52am. Refer to the interview with a second shift MA on 11/21/19 at 4:00pm. Refer to the interview with the RCC on 11/21/19 at 4:08pm.	D 358		

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D 358	Continued From page 56 Refer to the interview with the Business Office Manager (BOM) on 11/21/19 at 3:40pm. Refer to the interview with the Assistant Administrator (AA) on 11/21/19 at 3:00pm. Refer to the interview with the Administrator on 11/21/19 at 3:00pm. c. Review of Resident #7's current FL2 dated 08/20/19 revealed diagnoses included diabetes, neuropathy, hypertension, depression, and bipolar disorder. Review of Resident #7's physician's orders dated 08/26/19 revealed a physician's order for Novolog 100units/ml inject 5 units subcutaneously with meals; hold if fingerstick blood sugar (FSBS) is less than 120 or if patient does not eat a meal (used to treat diabetes). Review of Resident #7's November electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Novolog Flexpen 100units/ml inject 5 units subcutaneously with meals; hold if FSBS is less than 120 or if patient does not eat a meal scheduled to administer at 6:15am, 10:45am, and 3:45pm. -Novolog was administered at 6:15am, 10:45am, and 3:45pm for 45 out of 59 opportunities from 11/01/19 to 11/20/19. -On 11/02/19 at 3:45pm, the FSBS was 228 and no Novolog was administered. -On 11/04/19 at 3:45pm, the FSBS was 232 and no Novolog was administered. -On 11/06/19 at 6:15am and 10:45am, the FSBS was 156 and no Novolog was administered. -On 11/07/19 at 3:45pm, the FSBS was 126 and	D 358		

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no Novolog was administered.
-On 11/08/19 at 3:45pm, the FSBS was 207 and no Novolog was administered.
-On 11/11/19 at 3:45pm, the FSBS was 132 and no Novolog was administered.
-On 11/12/19 at 3:45pm, the FSBS was 132 and no Novolog was administered.
-On 11/13/19 at 3:45pm, the FSBS was 210 and no Novolog was administered.
-On 11/15/19 at 6:15am, the FSBS was 208 and no Novolog was administered.
-On 11/15/19 at 10:45am, the FSBS was 200 and no Novolog was administered.
-On 11/16/19 at 3:45pm, the FSBS was 212 and no Novolog was administered.
-On 11/20/19 at 6:15am, the FSBS was 157 and no Novolog was administered.
-On 11/20/19 at 10:45am, the FSBS was 120 and no Novolog was administered.

Observation of medications on hand for Resident #7 revealed one Novolog Flexpen was available to be administered with approximately 225 units remaining and an expiration date noted as 12/12/19.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/21/19 at 9:38am revealed:
-The pharmacy dispensed 4 Novolog Flexpens to Resident #7 on 07/29/19 with the directions inject 5 units subcutaneously three times daily before meals.
-Each Novolog Flexpen contained 300 units and expired 28 days after first use.

Interview with the medication aide (MA) on 11/22/19 at 4:41pm revealed:
-She did not give insulin to Resident #7 before lunch on 11/20/19 because the resident's FSBS

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was 120 and she thought this was outside of the parameters to administer the insulin.
-She administered medications based on the eMAR.

Interview with the Business Office Manager (BOM) on 11/21/19 at 8:10am revealed:
-She did not know why the MA was not administering insulin as ordered during the medication pass on 11/20/19.
-She thinks the MA was confused about the dose of insulin to administer to the residents.

Telephone interview with Resident #7's Primary Care Provider (PCP) on 11/25/19 at 9:45am revealed:
-Resident #7 had trouble with hyperglycemia in the past but her FSBS seemed to be controlled now.
-She did not know the facility was not administering her insulin correctly based on current order.
-Resident #7 should be administered insulin unless her FSBS was less than 120.
-Not administering the insulin correctly put Resident #7 at risk of hyperglycemia.
-Continued hyperglycemia increased the risk for dizziness, loss of motor control, palpitations, decline in kidney function, and macular degeneration.

Refer to the interview with a MA on 11/22/19 at 9:52am.

Refer to the interview with a second shift MA on 11/21/19 at 4:00pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 11/21/19 at 4:08pm.

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D 358	Continued From page 59 Refer to the interview with the BOM on 11/21/19 at 3:40pm. Refer to the interview with the Assistant Administrator (AA) on 11/21/19 at 3:00pm. Refer to the interview with the Administrator on 11/21/19 at 3:00pm. d. Review of Resident #11's current FL2 dated 08/26/19 revealed diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, heart failure, and fibromyalgia. i. Review of Resident #11's signed standing orders for medications and treatments dated 08/12/19 revealed a physician's order for Tylenol 500mg take 1 tablet every 4 hours as needed for up to 48 hours (used to treat pain and fever). Observation of the medication pass on 11/21/19 at 11:15am revealed: -Resident #11 asked the medication aide (MA) for Tylenol for pain. -The MA removed a stock bottle of Tylenol 500mg from the medication cart. -The bottle of Tylenol did not have a resident specific label on it. -The MA administered 2 tablets of Tylenol to Resident #11. -The MA did not review Resident #11's eMAR prior to administration. Review of Resident #11's November electronic Medication Administration Record (eMAR) revealed no computer-generated entry for Tylenol 500mg take 1 tablet every 4 hours as needed for up to 48 hours. Interview with Resident #11 on 11/22/19 at	D 358		

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2:50pm revealed:
-She needed the Tylenol to help with pain from fibromyalgia and a fractured disk.
-The MAs always gave her two tablets of Tylenol at a time.
-She also takes hydrocodone/Tylenol 5/325mg every 12 hours (used for pain).

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/21/19 at 4:55pm revealed:
-The pharmacy did not send over the counter (OTC) medications to each resident.
-The pharmacy dispensed OTC medications to the facility to use as "house stock."

Interview with the Resident Care Coordinator (RCC) on 11/21/19 at 4:08pm revealed:
-The MAs were responsible for checking the eMAR before administering any medications to the residents to make sure they were dispensing the correct medication and amount.
-The MAs were responsible for pulling the standing orders for each resident before administering a medication from the standing orders.
-All standing order medications dispensed to the residents should be documented in the "Nurse's Notes" notebook.

Telephone interview with Resident #11's Primary Care Provider (PCP) on 11/25/19 at 9:45am revealed:
-The MA should have looked at the standing order before administering the Tylenol.
-The facility was responsible for administering medications based on the physician orders, including the signed standing orders.
-It was important for her to know all the medications the resident received when she

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reviewed the eMAR prior to a visit.
-She never looked at the "Nurse's Notes" during a visit to the facility.
-Administering the incorrect dose of Tylenol increased Resident #11's risk of liver toxicity from Tylenol because she was also prescribed a scheduled pain medication that contained Tylenol.

Refer to the interview with a MA on 11/22/19 at 9:52am.

Refer to the interview with a second shift MA on 11/21/19 at 4:00pm.

Refer to the interview with the RCC on 11/21/19 at 4:08pm.

Refer to the interview with the Business Office Manager (BOM) on 11/21/19 at 3:40pm.

Refer to the interview with the Assistant Administrator (AA) on 11/21/19 at 3:00pm.

Refer to the interview with the Administrator on 11/21/19 at 3:00pm.

ii. Review of Resident #11's current FL2 dated 08/26/19 revealed a physician's order for Ventolin 90mcg inhaler inhale 2 puffs twice daily as needed for wheezing or shortness of breath (used to improve breathing related to asthma or COPD).

Observation of the medication pass on 11/21/19 at 11:30am revealed:
-Resident #11 came up to the medication aide (MA) during the medication pass and asked for her inhaler because she was having trouble breathing.
-The MA pulled the Ventolin inhaler out of the

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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

(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 358	Continued From page 62 medication cart and handed it to Resident #11. -Resident #11 inhaled 1 puff from the Ventolin inhaler and handed it back to the MA. -The MA pulled up Resident #11's electronic Medication Administration Record (eMAR) and could not find an entry to administer the Ventolin. Review of Resident #11's pharmaceutical review recommendation dated 10/07/19 revealed a signed physician's order to discontinue Ventolin inhaler due to non-use. Review of Resident #11's November 2019 eMAR revealed there was no computer-generated entry for Ventolin inhaler. Interview with Resident #11 on 11/22/19 at 2:50pm revealed: -She asked for her Ventolin inhaler occasionally. -The facility "usually" does not have the inhaler available on the medication cart and it takes several weeks for the medication to be delivered. -If the facility does not have the inhaler then she uses her oxygen to help her breath. -She was in the hospital last month for her breathing. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/21/19 at 4:55pm revealed: -A Ventolin inhaler was last dispensed to Resident #11 on 7/15/19 with the directions inhale 2 puffs twice daily as needed. -The pharmacy had received a discontinuation order for Ventolin on 10/07/19. Interview with the MA on 11/22/19 at 9:52am revealed: -Resident #11 asked for her inhaler on a regular basis.	D 358		

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D 358	Continued From page 63 -Resident #11 must wait 6 hours between doses. -She did not know the Ventolin inhaler for Resident #11 had been discontinued. Interview with the Resident Care Coordinator (RCC) on 11/21/19 at 4:08pm revealed: -The MAs were responsible for removing discontinued medications from the medication cart. -She did not know Resident #11's Ventolin inhaler was discontinued. -The MAs were responsible for checking the eMAR before administering medications to a resident. -The MAs should not be administering a medication to a resident if the medication is not on the eMAR. Telephone interview with Resident #11's Primary Care Provider (PCP) on 11/25/19 at 9:45am revealed: -The facility was responsible for administering medications based on the physician orders. -The MA should have checked the eMAR prior to administering the Ventolin. Refer to the interview with a MA on 11/22/19 at 9:52am. Refer to the interview with a second shift MA on 11/21/19 at 4:00pm. Refer to the interview with the RCC on 11/21/19 at 4:08pm. Refer to the interview with the Business Office Manager (BOM) on 11/21/19 at 3:40pm. Refer to the interview with the Assistant Administrator (AA) on 11/21/19 at 3:00pm.	D 358		

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Refer to the interview with the Administrator on 11/21/19 at 3:00pm.

e. Review of Resident #10's current FL2 dated 06/27/19 revealed diagnoses included anemia, hypertension, urinary retention, anxiety, chronic obstructive pulmonary disease (COPD), and diabetes.

Observation of the medication pass on 11/21/19 at 10:15am revealed:
-Resident #10 asked the medication aide (MA) for something for cough.
-The MA removed a bottle of Geri-Tussin liquid from the medication cart and administered 5ml to Resident #11 in the hallway.
-The bottle of Geri-Tussin (generic for Robitussin DM) did not have a resident specific label.
-The MA did not review Resident #10's eMAR prior to administration.

Review of Resident #10's signed standing orders for medications and treatments dated 08/09/18 revealed a physician's order for Robitussin DM syrup take 2 teaspoonsful (10ml) every 6 hours as needed for cough; do not use for more than 48 hours (used for cough).

Review of Resident #10's November electronic Medication Administration Record (eMAR) for Robitussin DM syrup take 2 teaspoonsful (10ml) every 6 hours as needed for cough; do not use for more than 48 hours.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/21/19 at 4:55pm revealed:
-The pharmacy did not send over the counter (OTC) medications to each resident.

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D 358	Continued From page 65 -The pharmacy dispensed OTC medications to the facility to use as "house stock." Interview with the Resident Care Coordinator (RCC) on 11/21/19 at 4:08pm revealed: -The MAs were responsible for checking the eMAR before administering any medications to the residents to make sure they were dispensing the correct medication and amount. -The MAs were responsible for pulling the standing orders for each resident before administering a medication from the standing orders. -All standing order medications dispensed to the residents should be documented in the "Nurse's Notes" notebook. Telephone interview with Resident #10's Primary Care Provider (PCP) on 11/25/19 at 9:45am revealed: -The MA should have looked at the standing order before administering the Geri-Tussin. -The facility was responsible for administering medications based on the physician orders, including the signed standing orders. -It was important for her to know all the medications the resident received when she reviewed the eMAR prior to a visit. Refer to the interview with a MA on 11/22/19 at 9:52am. Refer to the interview with a second shift MA on 11/21/19 at 4:00pm. Refer to the interview with the RCC on 11/21/19 at 4:08pm. Refer to the interview with the Business Office Manager (BOM) on 11/21/19 at 3:40pm.	D 358		

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Refer to the interview with the Assistant Administrator (AA) on 11/21/19 at 3:00pm.

Refer to the interview with the Administrator on 11/21/19 at 3:00pm.

2. Review of Resident #6's current FL2 dated 10/21/19 revealed:
-Diagnoses included cerebral infarction, chronic kidney disease, and gastroesophageal reflux disease (GERD).
-There was a physician's order for Coumadin 3mg take 1 tablet daily (used to prevent the blood from clotting).

Review of Resident #6's physician's orders dated 10/21/19 revealed a physician's order for Coumadin 1mg take 4 tablets (4mg) on Monday, Tuesday, and Wednesday and 3 and ½ tablets (3.5mg) on Thursday, Friday, Saturday, and Sunday.

Review of a telephone order for Resident #6 dated 10/24/19 revealed an order to hold coumadin until 10/28/19 due to an International Normalized Ratio (INR) (a blood test used to measure how quick blood clots) of 6.3 (normal range 2.5 to 3.5).

Review of "Nurse's Notes" dated 10/25/19 revealed Resident #6 was sent to the emergency room complaining of rectal bleeding.

Review of Resident #6's hospital discharge documentation dated 10/26/19 revealed:
-Resident #6's INR was above the normal range when he was examined in the emergency room with a value of 5.8.
-Resident #6's hemoglobin dropped from 13.41 to

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D 358	Continued From page 67 12.4 over a two-hour period while he was monitored in the ER. -Resident #6 was admitted to the hospital for monitoring on 10/25/19 and discharged on 10/26/19. -Resident #6 was diagnosed with rectal bleeding due to self-induced trauma due to constipation with an elevated INR. Review of Resident #6's October 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for Coumadin 3.5mg take 1 tablet daily scheduled to administer at 8:00pm. -The order had an original date of 10/18/19. -Coumadin 3.5mg was documented as administered daily from 10/19/19 to 10/23/19. -Resident #6 was out of the facility and in the hospital on 10/25/19 and 10/26/19. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/22/19 at 4:40pm revealed: -There were 25 tablets of Coumadin 1mg dispensed to Resident #6 on 10/18/19 with the directions take 3 and ½ (3.5mg) tablets daily for 1 week. -The pharmacy received an order on 10/24/19 to hold Coumadin until 10/28/19. -The pharmacy received an order for Coumadin 4mg take 1 tablet daily on 11/08/19 and dispensed 4 tablets on 11/08/19, 7 tablets on 11/12/19, and 14 tablets on 11/19/19. -The pharmacy only sends enough medication to cover until the next INR. Interview with Resident #6 on 11/22/19 at 9:40am revealed: -He had a heart valve replaced in 1995 and was	D 358		

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started on Coumadin.
-He had to get his blood checked once a week.

Interview with a medication aide (MA) on 11/22/19 at 4:41pm revealed:
-She could not remember what dose of Coumadin she administered to Resident #6 daily.
-She would go by the directions on the eMAR to administer medications to the residents.

Interview with the Resident Care Coordinator (RCC) on 11/22/19 at 3:04pm revealed she did not know why Resident #6 was sent to the hospital on 10/25/19 until she found the discharge summary from the hospital today (11/22/19).

Interview with the Business Office Manager (BOM) on 11/22/19 at 5:00pm revealed:
-She knew it was very important to make sure Resident #6's labs were followed closely, and the Coumadin was dosed accurately from the physician's orders.
-She followed Resident #6's INR and made sure the labs were drawn when ordered by the provider.
-The RCC and the MAs were responsible for administering the correct dose of Coumadin to Resident #6.

Telephone interview with a nurse from Resident #6's Cardiologist's office on 11/22/19 at 2:27pm revealed:
-Resident #6 was on Coumadin to prevent clotting from an artificial mitral valve.
-Resident #6's Nurse Practitioner (NP) was responsible for monitoring INR values and adjusting Coumadin doses.
-The facility was responsible for making sure Resident #6 was administered Coumadin as ordered.

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D 358	Continued From page 69 -It was very important for Resident #6's Coumadin dose to be monitored closely to prevent a blood clot from forming on the mechanical heart valve. -Resident #6's INR should be maintained between 2.5 and 3.5. -If the INR dropped below 2.5, Resident #6 was at risk for a stroke due to a blood clot and death. -If the INR was above 3.5, Resident #6 was at risk for death due to a spontaneous bleed from anywhere in the body. Refer to the interview with a MA on 11/22/19 at 9:52am. Refer to the interview with a second shift MA on 11/21/19 at 4:00pm. Refer to the interview with the RCC on 11/21/19 at 4:08pm. Refer to the interview with the BOM on 11/21/19 at 3:40pm. Refer to the interview with the Assistant Administrator (AA) on 11/21/19 at 3:00pm. Refer to the interview with the Administrator on 11/21/19 at 3:00pm. 3. Review of Resident #3's current FL2 dated 06/29/19 revealed: -Diagnoses included hyperlipidemia, hypertension, major depressive disorder, anxiety, osteoarthritis, and schizophrenia. -There was a physician's order for Neutrogena T-Sal Shampoo (salicylic acid) apply topically to the scalp, lather well and let sit for 5 to 10 minutes then rinse thoroughly every other day (used to treat dermatitis).	D 358		

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Review of Resident #3's physician order dated 10/28/19 revealed a physician's order to continue the Neutrogena T-Sal Shampoo apply topically to the face and scalp every other day.

Review of Resident #3's September, October, and November 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry for Neutrogena T-Sal Shampoo apply topically to scalp lather well, let sit for 5 to 10 minutes, then rinse thoroughly every other day; also use on face; wash every other day scheduled to administer at 7:00am.
-Neutrogena T-Sal Shampoo was documented as administered every other day from 09/01/19 to 11/22/19.

Observations of Resident #3's medication on hand on 11/20/19 at 4:45pm revealed there was no Neutrogena T-Sal shampoo available to administer to Resident #3.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/21/19 at 9:38am revealed:
-The pharmacy had dispensed 1 bottle of Neutrogena T-Sal Shampoo to Resident #3 on 01/21/19.
-This would cover the resident with medication for approximately 30 to 60 days depending on the size of the area it was being applied.
-The pharmacy did not have any documentation the facility had called to request a refill of the shampoo during the last 7 to 10 days.

Interview with Resident #3 on 11/20/19 at 9:58am revealed:
-He has had the soreson his head for several

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months.
-His head was "itchy" and he would have to try to "pat" his head to help stop the itching.
-He did not know he was supposed to have two different shampoos applied to his scalp.

Interview with a medication aide (MA) on 11/22/19 at 9:52am revealed:
-She had not been able to complete the weekly medication cart audit this week and did not know Resident #3's shampoo was not available.
-She did not know the shampoo was last dispensed in January 2019.
-She thought the shampoo had just "ran out" and the MA over the weekend had reordered the medication.
-Resident #3 only received medications from the facility's contracted pharmacy and no one else would have brought medicine to the facility for him.

Interview with a second shift MA on 11/21/19 at 4:00pm revealed:
-She did not know why Resident #3's shampoo was not available to administer.
-She did not remember when the shampoo was last available on the medication cart.

Interview with the Resident Care Coordinator (RCC) on 11/21/19 at 6:00pm revealed:
-She did not know the shampoo for Resident #3 was not available on the medication cart.
-She thought the Neutrogena shampoo had been discontinued when the Dermatologist started another shampoo.

Telephone interview with a nurse from Resident #3's Dermatologist's office on 11/21/19 at 3:01pm revealed:
-Resident #3 should still be administered the

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D 358	Continued From page 72 Neutrogena T-Sal shampoo. -There was no documentation that the resident was not receiving the medication as prescribed. -Resident #3 had multiple issues with his scalp including dermatitis. -The dermatologist had removed an area of squamous cell carcinoma from Resident #3's scalp in October 2019. -The Neutrogena T-Sal Shampoo was prescribed to breakdown the thick, scaly scabs the resident had on the top of his head so an antibiotic ointment could penetrate the scabs and reach the scalp. -The healing process was slowed down by not administering the shampoo, which could result in an increased risk of infection and worsening of the sores on Resident #3's head. -Resident #3 had a follow-up appointment in 1 week and the Dermatologist would assess how severe this was for the resident. Refer to the interview with a MA on 11/22/19 at 9:52am. Refer to the interview with a second shift MA on 11/21/19 at 4:00pm. Refer to the interview with the RCC on 11/21/19 at 4:08pm. Refer to the interview with the Business Office Manager (BOM) on 11/21/19 at 3:40pm. Refer to the interview with the Assistant Administrator (AA) on 11/21/19 at 3:00pm. Refer to the interview with the Administrator on 11/21/19 at 3:00pm. ____________________ Interview with a medication aide (MA) on 11/22/19	D 358		

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D 358	Continued From page 73 at 9:52am revealed: -She was responsible for auditing the medications on the cart to each resident's electronic Medication Administration Record (eMAR) weekly to make sure all medications were available to administer. -The pharmacy audited the medication carts monthly for expired medications. Interview with a second shift MA on 11/21/19 at 4:00pm revealed: -The first shift MAs were responsible for faxing new medication order to the pharmacy and auditing the medication cart. -She was responsible for administering medications based on the eMAR. -She was responsible for approving medication orders on the eMAR if an order "came through" during second shift. Interview with the Resident Care Coordinator (RCC) on 11/21/19 at 4:08pm revealed: -She or the MA on duty were responsible for faxing all new medication orders to the pharmacy for the pharmacy to enter on the eMAR. -She or the MA on duty were responsible for approving medication orders for the eMAR. -She or the MA on duty were responsible for auditing the new medication order with the entry on the eMAR before approving the entry. -She or the Business Office Manager (BOM) were responsible for auditing all medication orders approved by the MAs. Interview with the BOM on 11/21/19 at 3:40pm revealed: -She was not responsible for medication administration or auditing medication carts. -The RCC was responsible for monitoring the medication administration process.	D 358		

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-The RCC or the MAs were responsible for processing new medication orders.
-She would "fill-in" for the RCC if she was out.

Interview with the Assistant Administrator (AA) on 11/21/19 at 3:00pm revealed:
-The RCC and the BOM were responsible for processing new medication orders and for making sure medications were administered as ordered by a physician.
-The RCC and the BOM were responsible for auditing the medication carts every 2 weeks to make sure all medications were available for administration.
-The RCC or the MAs were responsible for approving medications for the eMAR.

Interview with the Administrator on 11/21/19 at 3:00pm revealed the AA was responsible for the day to day operations at the facility.

____

The facility failed to assure medications were administered as ordered by a physician for Resident #6 related to administering the wrong dose of Coumadin resulting in an elevated INR and an hospitalization for rectal bleeding increasing the risk of a spontaneous bleeding causing death, not administering a shampoo to Resident #3 that prolonged the healing process after cancer removal on the scalp increasing the risk of infection and discomfort, and not administering the correct dose of fast acting insulin to Resident #8 that resulted in an hospitalization for hyperglycemia increasing the risk of dizziness, loss motor control, palpitations, declining kidney function, and macular degeneration if hyperglycemia is not controlled. The facility's failure to administer medications as ordered by a physician put the residents at substantial risk for harm and neglect and

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D 358	Continued From page 75 constitutes a Type A2 violation. ______________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/22/19 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 25, 2019.	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 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 observations, interviews, and record reviews, the facility failed to ensure medication aides observed residents take their medications after administration for 3 of 14 residents related to leaving medications in the residents rooms (Resident #3, and #14). The findings are: Review of the facility's Pharmaceutical Policy and	D 366		

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D 366	Continued From page 76 Procedure Manual revealed: -The adult care home shall permit residents who are competent and physically able to self-administer their medications if the self-administration is ordered by a physician or other person legally authorized to prescribe medications and it is documented in the residents record. -The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time. - "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 resident actually taking the medication and prior to the administration of another resident's medication." 1. Review of Resident #1's current FL2 dated 08/26/19 revealed: -Diagnoses included dementia with behaviors, seizure disorder, history of cerebrovascular accident, myocardial infarction, and brain aneurysm. -There were no physician orders to self-administer medications. -There was a medication order for Preparation-H topical application three times a day as needed for hemorrhoids. -There was a medication order for Tylenol arthritis 650mg by mouth daily at bedtime. Observation on 11/20/19 at 9:40am revealed: -Resident #1 was in his room sitting on his bed. -There was a plastic medication cup containing one white tablet sitting on the night stand. -There was a tube of Preparation-H (an ointment	D 366		

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medication used to apply topically to hemorrhoids for pain relief), labeled with Resident #1's name, lying on top of his dresser.

Interview with Resident #1 on 11/20/19 at 9:40am revealed:
-The third shift MA on 11/19/19 left the white pill in the cup for him to take, "It's just Tylenol but I don't like taking it all of the time".
-He kept the tube of Preparation-H in his room to use when he needed it for painful hemorrhoids.
-One of the MA's gave him the Preparation-H to keep in his room.

Observation of Resident #1's room on 11/20/19 at 11:01am revealed:
-Resident #1 was not in his room.
-A white pill remained in a plastic medication cup on his nightstand.
-The tube of Preparation-H ointment was on his dresser.

Review of Resident #1's electronic Medication Administration Record (eMAR) for November 2019 revealed:
-There was a computer generated entry for hemorrhoidal ointement apply to rectal area topically three times a day as needed for hemorrhoids.
-There was no documentation the hemorrhoidal ointment had been administered.
-There was a computer generated entry for arthritis pain extended relief 650mg take one tablet by mouth at bedtime. No more than 3000mg acetaminophen from all sources in 24 hours.
-Arthritis pain extended relief was documented as administered at 8:00pm from 11/01/19 to 11/19/19.

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Interview with the Resident Care Coordinator (RCC) on 11/20/19 at 11:06am revealed:
-She did not know why Resident #1 had medications in his room and she would have to ask the Business Office Manager (BOM)/MA supervisor.
-The MA's were not supposed to leave medications in residents rooms unless the resident had a physician's order to self-administer medications.
-She expected the MA's to follow the facility's policies and procedures for administering medications.

Interview with the BOM/MA supervisor on 11/20/19 at 11:08am revealed:
-Resident #1 had been taken to his appointment for a colonoscopy procedure by transport.
-She did not know that Resident #1 had medications in his room given to him by the MA's.
-The MA's were not supposed to leave medications with residents.
-She expected the MA's to follow the facility's policies and procedures for administering medications.

Interview with the BOM/MA supervisor on 11/20/19 at 11:26am revealed:
-Medications such as inhalers, creams, ointments, and/or eye drops were stored on the medication cart and not supposed to be left in resident rooms.
-The MA should have watched Resident #1 take the medications and sign the eMAR after they were administered.

Attempted telephone interview with the MA on 11/21/19 at 10:26am was unsuccessful.

Interview with the Assistant Administrator (AA) on

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D 366	Continued From page 79 11/21/19 at 2:58pm revealed: -He did not know some MA's had left medications in resident rooms for them to self-administer. -It was the facility's policy for the MA to administer the medication, watch the resident take the medication, and document on the eMAR the medication was administered to the resident. -Medications were not to be left in resident rooms for them to self-administer unless the resident had a physician order to self administer medications. -He expected staff to follow the medication policies and procedures for administering medications. 2. Review of Resident #14's current FL2 dated 07/03/19 revealed: -Diagnoses included diabetes, chronic pain, depression, schizophrenia, chronic obstructive pulmonary disease, and history of lung cancer. -There was a medication order for Ventolin HFA inhaler (a medication inhaled to treat chronic inflammatory lung disease that causes obstructed airflow from the lungs) 90mcg inhale 2 puffs every 6 hours as needed for shortness of breath and wheezing. -There was a medication order for Flonase (a nasal spray to treat seasonal allergies) 0.05% nasal spray, spray once into each nostril once daily. -There were no physician orders to self-administer medications. Observation on 11/22/19 at 10:19am revealed: -Resident #14 was sitting on his bed in his room. -There was a Ventolin inhaler and bottle of Flonase labeled with Resident #14's name sitting on the nightstand in Resident #14's room. Interview with Resident #14 on 11/22/19 at	D 366		

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D 366	Continued From page 80 12:05pm revealed: -The MA's leave his nasal spray and inhaler in his room for him to self-administer. -He did not know how often the medications were ordered, "I just use it when I need it". -He did not report to the MA's when he used his inhaler or nasal spray. Interview with a first shift medication aide (MA) on 11/22/19 at 2:20pm revealed: -She thought Resident #14 could keep his Ventolin inhaler and Flonase nasal spray in his room. -She thought Resident #14 was supposed to use his inhaler and nasal spray every 6 hours. -She thought Resident #14 had an order to keep the Ventolin inhaler and Flonase nasal spray in his room. -Resident #14 would tell her when he had used his inhaler and nasal spray and she would document on the eMAR the medications were administered. Interview with the Resident Care Coordinator (RCC) on 11/22/19 at 2:48pm revealed: -Resident #14 did not have orders to self-administer his Ventolin inhaler or Flonase nasal spray. -She did not know why Resident #14 was self-administering the Ventolin inhaler or Flonase nasal spray to himself. -The MA's were not supposed to leave medications in residents rooms for self-administration unless they had a physician's order. -It was the facility's policy for the MA to administer the medication, watch the resident take the medication, and document on the eMAR the medication was administered to the resident. -She expected the MA's to follow the facility's	D 366		

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policies and procedures regarding medication administration.

Interview with Resident #14 on 11/22/19 at 2:58pm revealed:
-He had lived at the facility around 10 years and had self-administered his inhaler and nasal spray around three times per day since he had lived at the facility.
-He did not have a scheduled time to use his inhaler and nasal spray, he used them whenever he "can't breathe good".

Interview with the Assistant Administrator on 11/22/19 at 3:30pm revealed:
-He did not know why Resident #14 had a Ventolin inhaler and Flonase nasal spray in his room.
-He did not know if Resident #14 had a physician's order to self-administer medications.
-The BOM and RCC were responsible for filing the medication orders in the residents chart.
-It was the facility's policy for the MA to administer the medication, watch the resident take the medication, and document on the eMAR the medication was administered to the resident.
-The MA's were not supposed to leave medications in the residents room unless they had a physician's order to self-administer medication.
-He expected the MA's to follow the facility's policies and procedures for medication administration and storage.

2. Review of Resident #3's current FL2 dated 06/29/19 revealed diagnoses included hyperlipidemia, hypertension, major depressive disorder, anxiety, osteoarthritis, and schizophrenia.

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D 366	Continued From page 82 Observation on 11/20/19 at 4:10pm revealed: -The medication aide (MA) handed Resident #3 a medication cup as he entered the dining room. -Resident #3 walked across the dining room carrying the medication cup. -Resident #3 sat down at a table against the wall and put the medication cup on the table. -The medication cup contained one beige and tan capsule. -The MA returned to the medication cart and continued administering medications. Review of Resident #3's physician's orders revealed a physician's order dated 08/12/19 for Flomax 0.4mg take 1 capsule by mouth once daily 30 minutes after evening meal (used to treat urinary retention associated with an enlarged prostate). Interview with Resident #3 on 11/20/19 at 4:16pm revealed: -He was supposed to take the Flomax after he ate dinner. -The MA "trusts me to take my medicine." -The MA "gives me my medicine and lets me take it on my own." -The MA does not watch Resident #3 take his Flomax. Interview with a medication aide (MA) on 11/20/19 at 4:32pm revealed: -She "usually" watches Resident #3 take his Flomax. -Resident #3 was "peculiar about the timing" of the Flomax. -She gave the Flomax to Resident #3 so he would not get upset if she didn't give it to him at the correct time. -She knew she was supposed to watch Resident #3 take his medications.	D 366		

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D 366	Continued From page 83 Interview with the Resident Care Coordinator (RCC) on 11/20/19 at 11:06am and on 11/21/19 at 4:08pm revealed: -Resident #3 would get upset if he was not administered his Flomax at the same time everyday. -The MAs were supposed observe the residents take their medications unless the resident had a physician's order to self-administer medications. -She expected the MA's to follow the facility's policies and procedures for administering medications. Interview with the Assistant Administrator (AA) on 11/22/19 at 3:30pm revealed: -The MA's were not supposed to leave medications with the residents unless they had a physician's order to self-administer medication. -He expected the MA's to follow the facility's policies and procedures for medication administration and storage. Interview with the Administrator on 11/21/19 at 3:00pm revealed the AA was responsible for the day to day operations at the facility.	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	D 367		

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D 367	Continued From page 84 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 reviews, and interviews, the facility failed to assure the accuracy of the electronic Medication Administration Records (eMARs) for 2 of 13 residents (Resident #10 and #11) observed during a medication pass related to not documenting the administration of standing order medications. The findings are: 1. Review of Resident #11's current FL2 dated 08/26/19 revealed diagnoses included chronic obstructive pulmonary disease (COPD), hypertension, heart failure, and fibromyalgia. Review of Resident #11's signed standing orders	D 367		

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D 367	Continued From page 85 for medications and treatments dated 08/12/19 revealed a physician's order for Tylenol 500mg take 1 tablet every 4 hours as needed for up to 48 hours (used to treat pain and fever). Observation of the medication pass on 11/21/19 at 11:15am revealed: -The MA did not review Resident #11's eMAR prior to administration. -The MA did not document the administration of the Tylenol on Resident #11's eMAR. Review of Resident #11's November electronic Medication Administration Record (eMAR) revealed no computer-generated entry for Tylenol 500mg take 1 tablet every 4 hours as needed for up to 48 hours. Interview with Resident #11 on 11/22/19 at 2:50pm revealed: -She needed the Tylenol to help with pain from fibromyalgia and a fractured disk. -The MAs always gave her two tablets of Tylenol at a time. Telephone interview with Resident #11's Primary Care Provider (PCP) on 11/25/19 at 9:45am revealed: -The facility was responsible for documenting all medications a resident was administered on the eMAR. -It was important for her to know all the medications the resident received when she reviewed the eMAR prior to a visit. -She never looked at the "Nurse's Notes" while she was in the facility. Refer to interview with a medication aide (MA) on 11/21/19 at 10:16am.	D 367		

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D 367	Continued From page 86 Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 11/21/19 at 4:55pm. Refer to interview with the Resident Care Coordinator (RCC) on 11/21/19 at 4:08pm. Refer to interview with the Business Office Manager (BOM) on 11/21/19 at 3:40pm. Refer to interview with the Assistant Administrator (AA) on 11/21/19 at 3:00pm. Refer to interview with the Administrator on 11/21/19 at 3:00pm. 2. Review of Resident #10's current FL2 dated 06/27/19 revealed diagnoses included anemia, hypertension, urinary retention, anxiety, chronic obstructive pulmonary disease (COPD), and diabetes. Review of Resident #10's signed standing orders for medications and treatments dated 08/09/18 revealed a physician's order for Robitussin DM syrup take 2 teaspoonsful (10ml) every 6 hours as needed for cough; do not use for more than 48 hours (used for cough). Review of Resident #10's November electronic Medication Administration Record (eMAR) for Robitussin DM syrup take 2 teaspoonsful (10ml) every 6 hours as needed for cough; do not use for more than 48 hours. Observation of the medication pass on 11/21/19 at 10:15am revealed: -The MA did not review Resident #10's eMAR prior to administration. -The MA did not document the administration of	D 367		

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the Geri-Tussin on Resident #10's eMAR.

Telephone interview with Resident #10's Primary Care Provider (PCP) on 11/25/19 at 9:45am revealed:
-The facility was responsible for documenting all medications a resident was administered on the eMAR.
-It was important for her to know all the medications the resident received when she reviewed the eMAR prior to a visit.
-She never looked at the "Nurse's Notes" while she was in the facility.

Refer to interview with a medication aide (MA) on 11/21/19 at 10:16am.

Refer to telephone interview with a pharmacist from the facility's contracted pharmacy on 11/21/19 at 4:55pm.

Refer to interview with the Resident Care Coordinator (RCC) on 11/21/19 at 4:08pm.

Refer to interview with the Business Office Manager (BOM) on 11/21/19 at 3:40pm.

Refer to interview with the Assistant Administrator (AA) on 11/21/19 at 3:00pm.

Refer to interview with the Administrator on 11/21/19 at 3:00pm.

Interview with a medication aide (MA) on 11/21/19 at 10:16am revealed:
-She does not document administering any of the medications on the standing order on a resident's electronic Medication Administration Record (eMAR).
-The administration of medications on the

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standing orders were documented in the "Nurse's Notes."
-The MA's were responsible for completing the Nurse's Notes every shift.
-She had never documented the administration of a standing order on a Resident's eMAR during the three years she had worked at the facility as a MA.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/21/19 at 4:55pm revealed:
-The facility specific standing orders are automatically loaded in the eMAR.
-The MA should be able to look up a specific standing order and add the order to the eMAR.

Interview with the Resident Care Coordinator (RCC) on 11/21/19 at 4:08pm revealed:
-The MAs were responsible for documenting the administration of medications from the standing orders in the "Nurse's Notes" notebook.
-The MAs never documented the standing order administration on the eMAR.
-The MAs should look up the standing order before administering medication to make sure of the correct dose.

Interview with the Business Office Manager (BOM) on 11/21/19 at 3:40pm revealed:
-She did not know the standing orders were not listed or documented as given on the eMARs.
-She would work to make sure the standings orders were added to the eMAR for each resident.
-The RCC was responsible for making sure the eMARs were correct and monitoring the medication administration process.

Interview with the Assistant Administrator (AA) on

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(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 367	Continued From page 89 11/21/19 at 3:00pm revealed: -He did not know the administration of the standing orders were not being documented on the eMAR. -The RCC and the BOM were responsible for making sure the eMARs were correct and overseeing the medication administration process. Interview with the Administrator on 11/21/19 at 3:00pm revealed the AA was responsible for the day to day operations at the facility.	D 367		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to complete Health Care Personnel Registry (HCPR) reporting and investigation requirements within the 24 hour and 5-day requirements for 3 of 3 sampled resident (#4, #12 and #13) who were subjected to verbal abuse and sustained bruises to their arm. 1. Review of Resident #4's FL-2 dated 10/21/19 revealed diagnoses included candidiasis of skin and nails, Type 2 diabetes, retention of urine and central pontine myelinolysis.	D 438		

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D 438	Continued From page 90	D 438		

Review of Resident #4's record revealed an admission date of 10/21/19.

Interview Resident #4 on 11/22/19 at 2:29pm revealed:
-A PCA stated to her that, "This is not a nursing home" about three months ago.
-The comment was stated because of "my health care needs."
-It made her "Feel some kinda way", "hurt" and "mad".
-She reported the incident to the BOM.
-The PCA was still employed.

Interview with a relative on 11/22/19 at 10:59am revealed:
-Resident #4 had been a resident for about four months.
-The resident had not reported having any issues with the staff.
-Resident #4 had a fall but the staff did not notify him of the fall.
-He learned of the fall from a relative who Resident #4 had informed them of the fall.
-He was no longer involved in attending Resident #4's medical appointments because he was not informed of the appointments.

Refer to Interview with the Medication Aide (MA) on 11/21/19 at 4:48pm.

Refer to interview with a second Medication Aide (MA) on 11/22/19 at 2:08pm.

Refer to Interview with Business Officer (BOM) on 11/22/19 at 3:12pm.

Refer to Interview with Assistant Administrator on 11/22/19 at 3:12pm.

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D 438	Continued From page 91 2. Review of Resident #12's current FL2 dated 09/25/19 revealed diagnoses included insomnia, bipolar, diabetes, and hypertension. Interview with Resident #12 on 11/22/19 at 2:00pm revealed: -"That girl tried to turn" his arm. -"That girl hurt my arm." -"That girl person twisted" his neck and his "Adam's apple." -He did not remember when the incident occurred, but stated it happened "a while ago." -He reported the incident to the "Owner". -"The girl" still worked at the facility and had worked on today. -He was taken to the hospital and he told the hospital staff what happened to his arm. Interview with the Personal Care Aide (PCA) on 11/22/19 at 2:47pm revealed: -She noticed a large red bruise on Resident #12 right arm when she reported to work at 5:30am. -The incident occurred about two months ago on the third shift. -Resident #12 was crying and said, "Look at what she did to me." -Resident #12 stated that "a girl did it" and pointed out "the girl" as a staff who had bruised his arm. -Resident #12 had fallen later than day around 12:00pm and was taken to the hospital. -The PCA reported the incident to the Assistant Administrator. -The PCA stated the Assistant Administrator was "shocked" and "angry" and that he was going to address the incident. -The staff was a PCA and was still employed. Refer to Interview with the Medication Aide (MA)	D 438		

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D 438	Continued From page 92 on 11/21/19 at 4:48pm. Refer to interview with a second Medication Aide (MA) on 11/22/19 at 2:08pm. Refer to the interview with the Resident Care Coordinator on 11/22/19 at 10:55am Refer to Interview with the Business Officer Manager (BOM) on 11/22/19 at 3:12pm. Refer to Interview with the Assistant Administrator on 11/21/19 at 6:26pm. ________________ Interview with the Medication Aide (MA) on 11/21/19 at 4:48pm revealed: -She had received complaints from residents about staff yelling and being "rude" towards the residents. -She had not witness the PCAs being rude to the residents. -Had addressed the residents' concern of the PCAs being rude towards the residents. -She had reported residents' concerns to the BOM and RCC. Interview with a second MA on 11/22/19 at 2:08pm revealed: -Some residents had brought their concerns about the PCAs to her attention. -She always reported those concerns to the BOM. -She was aware of a PCA stating to Resident #4, "This is not a nursing home." -The PCA also stated to Resident #4, "She needed to start doing for herself." - Resident #4 informed her of the PCA behavior towards the resident. -The incident occurred about three months. -She did supervisor the PCA when assigned to	D 438		

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D 438	Continued From page 93 her shift. -She reported the incident of the PCA comments to the BOM. -The MA was informed of Resident #12's incident. -She noticed there was a red bruise on Resident#12's right arm. -Resident #12 informed her that "a girl twisted" his arm. -The MA did not know why the incident occurred. -The MA reported the incident to Assistant Administrator. -The MA stated the Assistant Administrator was upset about the incident. -She did not know if the PCA was reprimanded. -The PCA was still employed. Interview with the Resident Care Coordinator (RCC) on 11/22/19 at 10:15am revealed: -Residents had not complained about staff in over three months. -Residents reported their concerns about staff to the BOM because she had a better rapport with them. -Some staff had been suspended for the use of profanity towards the residents. -Residents' complaints are documented. -She was not sure if any residents had brought their concerns the MAs. -She did a random check with residents and asked if they had any issues, concerns or complaints. -She reported all complaints received to the BOM and the Assistant Administrator. -Staff received in-service training on customer service and residents' rights. -The last in-service training was held on 07/18/19. -In-service trainings are mandatory for all staff. -Staff received a written reprimand if they failed to attend the training. -She had not issued any written reprimands to	D 438		

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D 438	Continued From page 94	D 438		

staff relating to violating residents' rights.
-She expected staff treat the residents with dignity and respect.

Interview with Business Officer Manager (BOM) on 11/22/19 at 3:12pm.
-Most residents reported their issues and concerns about staff to her.
-Resident #4 reported the issue of the staff stating "This is not a nursing home" to her.
-She had verbally addressed the PCA for making the comment to Resident #4.
-The PCA was not suspended for this incident.
-The PCA had been suspended about one month ago for not giving a resident a shower.
-The incident involving Resident #4 was not reported to the Health Care Personnel Registry (HCPR).
-Resident #12 reported to the MA that a staff member had twisted and bruised his arm.
-The Assistant Administrator informed the BOM about Resident #12's arm being bruised by staff.
-The staff was no loner an employee when she had learned who the staff was that bruised Resident #12's arm.
-She did not report the incident to the HCPR.
-Staff had received training relating to residents' rights in July 2019.
-Another in-service training was scheduled for December 2019 on residents' rights.
-She expected all the staff to be respectful and kind to the residents and assist them with all their needs.

Interview with the Assistant Administrator (AA) on 11/22/19 at 3:12pm revealed:
-He had been made award of the "This is not a nursing home" comment to Resident #4.
-The incident occurred about three months ago.
-The PCA had received a verbal reprimand but

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FORM APPROVED

Division of Health Service Regulation

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D 438	Continued From page 95 was not suspended. -The PCA had been terminated twice but was rehired. -The PCA had also been suspended previously for her behavior towards residents. -An anger management in-service training was provided to the staff as it related to residents' rights. -Staff meetings are held regularly and are mandatory. -The last staff meeting was held in October 2019 and residents' rights was addressed. -He did not tolerate staff mistreating residents. -He was upset to learn of the comment made to Resident #4. -He had not made any reports to HCPR.	D 438		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to report to the County Department of Social Services a fall for 1 of 2	D 451		

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D 451	Continued From page 96	D 451		

sampled residents (Resident #6), which required referral for emergency medical evaluation.

The findings are:

Review of Resident #6's current FL2 dated 10/21/19 revealed diagnoses included cerebral infarction, chronic kidney disease, and gastroesophageal reflux disease (GERD).

Observation of Resident #6 on 11/20/19 at 10:20am revealed:
-He was in his room walking from the bed to a chair with a gait belt around his waist and a woman (who identified herself as a Physical Therapist) holding onto the gait belt.
-He had an unsteady gait.
-He was wearing a sling on his right arm.

Review of the Incident and Accident Reports for Resident #6 revealed there was no documentation an Incident and Accident Report was completed on 10/18/19 when Resident #6 fell and sustained a head injury and separated his right shoulder with a break in the right clavicle bone.

Interview with Resident #6 on 11/21/19 at 9:40am revealed he recently fell between the two beds in his room, hit his head and separated his right shoulder and had to go to the hospital for medical evaluation.

Interview with the RCC on 11/22/19 at 11:59am revealed:
-It was the facility's policy for the MA to fill out an Incident and Accident Report when a resident fell.
-Incident reports were filed in a notebook at the nurses station.
-There were two incident reports for Resident #6

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D 451	Continued From page 97	D 451		

dated 10/20/19 and 10/21/19.
-Resident #6 had fallen in his room on 10/18/19 and broke his right clavicle.
-She did not know why the MA on duty did not fill out an incident report on 10/18/19 for Resident #6 when he fell.
-The MA would give the incident report to the BOM and she would fax it to the local DSS.
-The BOM would give her the incident report and she would file it into the notebook they kept at the nurses station.

Interview with the BOM on 11/22/19 at 11:14am revealed:
-The PCA reports to the MA and "me" when a resident fell.
-She or the MA would call 911 or the residents attending physician and send the resident to the hospital for medical evaluation if the resident was injured.
-The MA notified the family when a resident had an accident and would fill out an Incident and Accident Report.
-She did not have any Incident and Accident reports for Resident #6 that were not filed in the Incident and Accident Report notebook.
-She did not know why the MA on duty did not fill out an incident report for Resident #6 when he fell on 10/18/19.

Interview with the Assistant Administrator (AA) on 11/22/19 at 11:45am revealed:
-The MA was responsible for filling out Incident and Accident Reports and giving them to the BOM when a resident fell.
-The BOM and RCC were responsible for faxing Incident reports to the local DSS and filed them into a notebook.
-He was not aware an Incident and Accident Report was not filled out for Resident #6 on

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D 451	Continued From page 98 10/18/19 when he fell and separated his right shoulder and broke his right clavicle. -He expected staff to follow the facility's policies and procedures for falls and fill out Incident and Accident Reports.	D 451		
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 ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Resident Rights. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure 7 of 15 residents were free of neglect and physical abuse related to Resident #12 being physically abused after an altercation with Staff A, Resident #4 not being treated with respect and dignity related to incontinence care, staff cussing and being disrespectful to multiple residents (Resident #4, #5, #11, #13, and #15), and being afraid to voice a concern due to retaliation by the staff (Resident #3) [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D911		

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D912	Continued From page 99	D912		
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 observations, interviews, and record reviews, the facility failed to assure residents received care and services that are adequate, appropriate, and in compliance with federal and state laws and rules and regulations related to medication administration, staff training on diabetic care, and health care implementation. The findings are: 1. Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled Medication Aides (Staff B and C) who administered insulin to residents completed training on the care of diabetic residents prior to the administration of insulin [Refer to Tag 164, 10A NCAC 13F .0505 Training on Diabetic Care (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure the implementation of physician's orders for 2 of 5 sampled residents for administering a medication to cleanse the bowels for a colonoscopy procedure (Resident #1) and applying a lymphedema intermittent pneumatic compression	D912		

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D912	Continued From page 100 pump (a device used to treat leg swelling by inflating sleeves that squeeze the legs to promote blood flow to prevent blood clots) (Resident #3) [Refer to Tag 276, 10A NCAC 13F .0902(c)4 Health Care (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a physician for 5 of 13 residents observed during the medication pass (Residents #7, #8, #9, #10, and #11) and 2 of 6 sampled residents (Residents #3 and #6) related to not administering the correct dose of a blood thinner (#6), not administering the correct dose of fast acting insulin (#7, #8), administering pain medication as needed when the medication order was for scheduled dosing (#9), administering the incorrect dose of two medications listed on the standing orders (#10, #11) and not having a shampoo available to help improve healing after having cancer removed from the scalp (#3) [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 4. Based on recommendations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for medication administration, health care implementation, accuracy of the electronic mediation administration record (eMAR), resident rights, maintaining an operational call system, supervision, activities, food contamination, health care personal registry, medication aide written exam, and training on diabetic care, infection control, and restraints [Refer to Tag 980, GS 131D-25 Implementation (Type A2 Violation)].	D912		

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D914	Continued From page 101	D914		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Resident Rights. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure 7 of 15 residents were free of neglect and physical abuse related to Resident #12 being physically abused after an altercation with Staff A, Resident #4 not being treated with respect and dignity related to incontinence care, staff cussing and being disrespectful to multiple residents (Resident #4, #5, #11, #13, and #15), and being afraid to voice a concern due to retaliation by the staff (Resident #3) [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D914		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health	D934		

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D934	Continued From page 102	D934		

Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled Medication Aides (Staff B) had completed the mandatory infection control training before checking fingerstick blood sugars and administering insulin to residents.

The findings are:

Review of Staff B's, Medication Aide (MA), personnel record revealed:
-Staff B was hired on 10/14/19.
-There was no documentation Staff B had completed infection control training.

Review of a resident's November 2019 electronic Medication Administration Record (eMAR)

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	HAL043003	A. BUILDING: ______ B. WING ______	R 11/25/2019

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D934	Continued From page 103 revealed: -Staff B performed fingerstick blood sugars (FSBS) on 11/01/19, 11/05/19, 11/08/19, 11/09/19, 11/14/19, 11/15/19, 11/17/19, and 11/19/19. -Staff B administered insulin on 11/01/19, 11/05/19, 11/08/19, 11/09/19, 11/14/19, 11/15/19, 11/17/19, and 11/19/19. Attempted telephone interview with Staff B on 11/21/19 at 10:26am was unsuccessful. Interview with the BOM on 11/21/19 at 9:15am revealed: -The RCC and herself were responsible for scheduling the training needed for employees either by online training, with the pharmacy, or with the facility's contracted nurse. -Staff B had checked fingerstick blood sugars (FSBS) and administered insulin injections to residents. -She was responsible for auditing personnel records "ever so often" for expired and/or completed training. -She missed Staff B had not completed her infection control training when she audited her personnel record. Interview with the RCC on 11/21/19 at 9:38am revealed: -Either herself or the BOM scheduled new employees for their required training. -She could not provide documentation of infection control training for Staff B. -The facility's contracted pharmacy provided the infection control training. -The BOM was responsible for auditing personnel records for expired and/or completed training. -Staff B had checked FSBS and administered insulin injections to residents.	D934		

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D934	Continued From page 104 Interview with the Assistant Administrator (AA) on 11/21/19 at 2:58pm revealed: -He was responsible for the daily operations of the facility. -He did not know that Staff B had not completed the infection control training. -The RCC and BOM were responsible for scheduling required training for staff. -He knew that Staff B had checked FSBS and administered insulin to diabetic residents. -His expectation was for all personnel records to be monitored and updated with current training documentation.	D934		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (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	D935		

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D935	Continued From page 105 exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (Staff C) had taken and successfully passed the written medication exam within 60 days of completion of the medication administration clinical skills validation. The findings are: Review of Staff C's personnel's record revealed: -Staff C had completed the 15-hour Medication Training on 05/21/19.	D935		

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D935	Continued From page 106 -Staff C was competency validated on 05/21/19 for Medication Clinical Skills Checklist. -There was no documentation that Staff C had passed the Medication Aide (MA) examination. Review of a resident's electronic Medication Administration Record (eMAR) from October 2019 revealed: -Staff C documented she had administered the residents medications on 10/26/19 and 10/27/19 at 7:00am. -Staff C documented she had administered the residents medications on 10/27/19 at 10:45am. -Staff C documented she had administered the residents medications on 10/03/19, 10/13/19, 10/22/19, and 10/23/19 at 3:45pm and 8:00pm -Medications documented as administered by Staff C included antibiotics and insulin. Review of another resident's eMAR from November 2019 revealed: -Staff C documented she had administered the residents medications on 11/09/19 and 11/10/19 at 7:00am and 8:00pm. -Staff C documented she had administered the residents medications on 11/10/19 at 6:00am and 10:00pm. -Medications documented as administered by Staff C included anticonvulsants, narcotics, and anti-anxiety medications. Telephone interview with Staff C on 11/21/19 at 10:30am revealed: -She was working at the facility as a Personal Care Aide (PCA) and MA "in training". -She had previously taken the MA exam but did not pass and she had rescheduled to retake the examination. -She administered medications and insulin injections to residents while supervised by	D935		

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D935	Continued From page 107 another MA. Review of the staffing schedule for 11/15/19 revealed Staff C was the only MA on duty for the 11:00pm to 7:00am shift and had administered medications during this shift. Interview with the Business Office Manager (BOM) on 11/21/19 at 9:15am revealed: -Staff C was training to be a MA but was supervised by another MA when administering medications to residents. -She could not recall when Staff C had taken the MA examination but she did not pass. -She did not know why Staff C had not retaken the MA examination. Interview with the Resident Care Coordinator (RCC) on 11/21/19 at 9:38am revealed: -The BOM was responsible for auditing personnel records for expired and/or completed training. -Staff C had not passed her MA examination, but they were allowing Staff C to administer medications while supervised by another MA until she retook the MA examination and successfully passed. -She knew that Staff C had to successfully pass the MA examination within 60 days of completion of the Medication Clinical Skills Checklist. -She did not know why Staff C had not retaken the MA examination yet. Interview with the Assistant Administrator (AA) on 11/21/19 at 2:58pm revealed: -The BOM and RCC were responsible for monitoring personnel records to make sure training was completed. -Staff C failed her MA examination. -Staff C was administering medications to residents.	D935		

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D935	Continued From page 108 -He did not know why Staff C had not retaken the MA examination. -He did not know Staff C could not administer medications to residents until she had retaken the MA examination and successfully passed.	D935		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on recommendations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for medication administration, health care implementation, accuracy of the electronic mediation administration record (eMAR), resident rights, maintaining an operational call system, supervision, activities, food contamination, health care personal registry, medication aide written exam, and training on diabetic care, infection control, and restraints. The findings are: Interview with the Administrator on 11/21/19 at 11:40am and 3:00pm revealed: -He "took back over" the facility during the past year.	D980		

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D980	Continued From page 109	D980		

-Previously, he had retired and was letting the Assistant Administrator (AA) manage the facility.
-During the past year, he started visiting the facility frequently.
-He was working to improve the facility by replacing the flooring, resident beds, and painting the walls.
-The AA was still responsible for the day to day operations of the facility and making sure the staff followed facility policies and procedures.
-He did not know any specifics related to the personal care of the residents.

Interview with the AA on 11/21/19 at 3:00pm revealed:
-He was responsible for monitoring the day to day operations of the facility including the banking needs of the facility, transportation, structural needs, and the care of the residents.
-He was "very hands-on with the residents."
-The Administrator lived next door to the facility and was always available by phone.
-He did not know the specific details related to medication order processing.
-The Resident Care Coordinator (RCC) and the Business Office Manager (BOM) were responsible for monitoring the medication order processing procedures.
-The RCC and the medication aides (MA) were responsible for approving medications and the accuracy of the eMARs.
-The facility was understaffed and they could not find good help.
-Recently, he fired a staff member hired as a MA because of drug diversion.
-He, the RCC, and the BOM was always at the facility.
-The BOM was responsible for clerical duties only.
-All staff had recently attended a training

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D980	Continued From page 110 regarding resident rights. Interview with a Personal Care Aide (PCA) on 11/22/19 at 2:40pm revealed she reported to the MA on duty or the BOM if they had a concern about a resident or a problem. Interview with the BOM on 11/21/19 at 3:40pm revealed: -She was responsible for staffing, scheduling resident appointments, managing the kitchen and ordering the food, filling in for the RCC, assisting with controlled substance inventory, and making sure the residents were happy. -She was working first shift today (11/21/19) and she had to be back by 11:00pm to work third shift. -It was common for her to work a double shift on the same day. -She tried to do everything herself to make sure it was completed correctly. Interview with the RCC on 11/21/19 at 4:08pm revealed: -She worked when the facility needed her. -She was responsible for organizing activities for the residents. -She was confused about which activities were scheduled for 11/20/19 and completed the activities scheduled on another day. -She was responsible for auditing all new medication orders and supervising the MAs. -She did not know the standing orders needed to be documented on the electronic Medication Administration Record (eMAR). -The MAs were responsible for reviewing the eMAR prior to medication administration. Non-compliance was identified at the violation level in the following rule areas:	D980		

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D980	Continued From page 111 1. Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled Medication Aides (Staff B and C) who administered insulin to residents completed training on the care of diabetic residents prior to the administration of insulin [Refer to Tag 164, 10A NCAC 13F .0505 Training on Diabetic Care (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure the implementation of physician's orders for 2 of 5 sampled residents for administering a medication to cleanse the bowels for a colonoscopy procedure (Resident #1) and applying a lymphedema intermittent pneumatic compression pump (a device used to treat leg swelling by inflating sleeves that squeeze the legs to promote blood flow to prevent blood clots) (Resident #3) [Refer to Tag 276, 10A NCAC 13F .0902(c)4 Health Care (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to assure 7 of 15 residents were free of neglect and physical abuse related to Resident #12 being physically abused after an altercation with Staff A, Resident #4 not being treated with respect and dignity related to incontinence care, staff cussing and being disrespectful to multiple residents (Resident #4, #5, #11, #13, and #15), and being afraid to voice a concern due to retaliation by the staff (Resident #3) [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered by a physician for 5 of 13 residents observed during the medication pass (Residents #7, #8, #9, #10, and #11) and 2 of 6 sampled residents (Residents #3 and #6) related	D980		

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D980	Continued From page 112 to not administering the correct dose of a blood thinner (#6), not administering the correct dose of fast acting insulin (#7, #8), administering pain medication as needed when the medication order was for scheduled dosing (#9), administering the incorrect dose of two medications listed on the standing orders (#10, #11) and not having a shampoo available to help improve healing after having cancer removed from the scalp (#3) [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)]. 5. Based on recommendations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for medication administration, health care implementation, accuracy of the electronic mediation administration record (eMAR), resident rights, maintaining an operational call system, supervision, activities, food contamination, health care personal registry, medication aide written exam, and training on diabetic care, infection control, and restraints [Refer to Tag 980, GS 131D-25 Implementation (Type A2 Violation)]. The Administrator's failure to assure responsibility for the overall operation of the facility resulted in significant non-compliance with state rules and regulations related to mulitiple residents (Resident #4, #12, and #3) not being treated with dignity and respect related to verbal and physical abuse, administering medications as ordered related to Resident #6 was administered the incorrect dose of Coumadin resulting in an hospitalization for rectal bleeding and an increased risk for life-threatening spontaneous bleeding, Resident #3 was not administered Neutrogena T-Sal Shampoo for 10 months slowing the healing process of wounds on his	D980		

Division of Health Service Regulation

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D980	Continued From page 113 scalp increasing the risk for infection, and Resident #8 not administered Novolog as ordered resulting in an hospitalization for hyperglycemia and fluctuating blood sugar readings that increased the risk of kidney damage and macular degeneration from prolonged hyperglycemia, the staff was not trained appropriately on infection control, restraint use, and diabetic care, a medication aide was administering medication without passing the written medication aide examination, health care implementation regarding a medication for a bowel preparation prior to a colonoscopy for Resident #1 resulting in an incomplete bowel prep and having to use specialized equipment to complete the colonoscopy and Resident #3 not being applied a lymphedema intermittent pneumatic compression pump to his legs to improve circulation increasing the risk for edema and a diabetic ulcer. This failure to assure responsibility for the overall administration, management, and supervision of the facility put the residents at substantial risk for harm and neglect and constitutes a Type A2 violation. ______ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/22/19. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 25, 2019.	D980		