STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043035	A. BUILDING: _____ B. WING _____	R 09/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOHNSON BETTER CARE FACILITY	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 a follow-up survey from 09/01/26 to 09/02/26.	{D 000}		
{D 077}	10A NCAC 13F .0306 (a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a sanitation report in accordance with one of the following: (A) a North Carolina Department of Health and Human Services, Division of Public Health, Environmental Health Section approved sanitation classification at all times in facilities with 12 beds or less, pursuant to the "Rules Governing the Sanitation of Residential Care Facilities", 15A NCAC 18A .1600, which are incorporated by reference including all subsequent amendments and can be accessed electronically free of charge at http://ehs.dph.ncdhhs.gov/rules.htm; and (B) a North Carolina Department of Health and Human Services Division of Public Health, and Environmental Health Section sanitation scores of 85 or above at all times in facilities with 13 beds or more. The "Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes, and Other Institutions", 15A NCAC 18A .1300, can be accessed electronically free of charge at http://ehs.dph.ncdhhs.gov/rules.htm. Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.	{D 077}		

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{D 077}	Continued From page 1	{D 077}		

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE B VIOLATION

Based on these findings, the previous Type B Violation was not abated.

Based on interviews and record reviews, the facility failed to ensure a sanitation report from the North Carolina Department of Health and Human Services Division of Public Health Environmental Health Section scored 85 or above at all times in the facility and the kitchen.

The findings are:

1. Review of the facility's North Carolina Department of Health and Human Services Division of Public Health Environmental Health Section Inspection of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions report dated 06/16/26 revealed:
-There were 21 total deductions.
-The score was 79.

Telephone interview with a local Environmental Health Inspector on 09/01/26 at 11:10am revealed:
-The facility had not contacted their office for a reinspection of the facility or the kitchen.
-The biggest concern in the facility on 06/16/26 during the inspection was the cleanliness of the facility.
-The facility staff were using the dirty hamper during laundry to store clean linen and clothes.
-There were numerous flies flying around especially in one shared residents' room.
-There were residents' rooms that needed to be

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{D 077}	Continued From page 2 cleaned, debris, furniture and ceilings were not in good repair, and there was fecal matter as well as urine splattered in the toilets. -The fecal matter was dried up in shared residents' bathrooms. -It appeared the toilet lids were being cleaned on the top, but when they were lifted dried fecal matter was observed inside the toilet and under the bottom of the toilet lids. -Fecal matter and urine could hold a lot of bacteria and diseases and if left for extended periods could cause health risk and cause bacteria and diseases to transfer from resident to resident. Refer to interview with the Administrator on 09/01/26 at 11:39am. 2. Review of the facility's North Carolina Department of Health and Human Services Division of Public Health Environmental Health Section Food Establishment Inspection report dated 08/19/26 revealed: -There were 19.5 total deductions. -The score was 80.5. Telephone interview with a local Environmental Health Inspector on 09/01/26 at 11:10am revealed: -The facility had not contacted their office for a reinspection of the facility or the kitchen. -There were employees in the kitchen who did not wash their hands after entering the kitchen. -The kitchen staff needed to practice good hygiene by washing their hands to prevent Escherichia coli (E. coli). (E. coli is a bacteria that could be transmitted when a person did not wash their hands after using the bathroom). -There was food thawed in the sink next to soiled rags.	{D 077}		

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{D 077}	Continued From page 3 -Food should not be thawed in the sink next to soiled rags because water from the soiled rags could splash onto the food which could lead to contamination. -There was food that was left in the temperature danger zone which could cause illness. -Keeping food out of the temperature danger zone allowed the facility to prevent the least amount of bacteria from growing. -The kitchen needed to ensure food that needed to be held at 135 degrees or above or below 41 degrees. -The kitchen staff served unpasteurized eggs, which should not be served to high accessible populations like the elderly because eggs have a risk for salmonella and other harmful bacteria. (Salmonella is a bacteria that can cause a painful intestinal infection. It is the leading cause of foodborne illness). -The pasteurization eliminated the risk for foodborne illness. Refer to interview with the Administrator on 09/01/26 at 11:39am. [Refer to tag D 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings] _____ Interview with the Administrator on 09/01/26 at 11:39am revealed: -She had not requested a reinspection of the facility or kitchen from the Environmental Health Section. -She wanted to ensure everything that she could fix was fixed before she called the Environmental Health Section for a reinspection. _____ The facility's failure to ensure there was a sanitation score of 85 or above in the facility and the kitchen from the North Carolina Department	{D 077}		

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{D 077}	Continued From page 4 of Health and Human Services Division of Public Health Environmental Health Section was detrimental to the health and safety of the residents and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/01/26 for this violation.	{D 077}		
{D 079}	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide a safe and clean environment related to the presence of flies throughout the facility, dirty linen on beds, trash cans full at the bedside, water left in the floor of a resident room from a leaking air conditioning unit which had black residue on the front vents. The findings are:	{D 079}		

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{D 079}	Continued From page 5 Review of the facility's North Carolina Department of Health and Human Services Division of Public Health Environmental Health Section Inspection of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions report dated 06/16/26 revealed: -There were 21 total demerits. -There were 2 demerits for floors and carpets clean and in good repair noting an accumulation of dust and residue under beds, furniture and along floor and wall junctures. -There were 2 demerits for walls and ceiling clean and in good repair noting resident rooms had debris on walls, damaged doors, windows had debris on many window sills, covering on walls were missing, damaged or loose. -There was 1 demerit for for presence of pests noting heavy fly presence in the facility. -There was 0.5 demerits for ventilation equipment clean and in good repair. -There was 1 demerit for furnishings clean and in good repair noting pillows and bed linens was stained and worn, bedside furniture was dirty and needed cleaning. -The score overall score was 79. a. Observation of a resident room on 09/01/26 at 9:01am revealed: -There was water on the floor under the air conditioning unit near the floor at the head of the bed. -There was a bottle of drain cleaner that was used to support the front of the unit. -There was a black substance on the air outflow vents of the air conditioning unit and dirt and debris down the front of the air conditioning unit . -There was dirt, hair and debris on the floors. Interview with the resident who resided in the room on 09/01/26 at 9:01am revealed:	{D 079}		

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{D 079}	Continued From page 6 -There had been water in her bedroom floor for approximately 2 weeks. -The bottle of drain cleaner was placed under the unit by staff to support the front so it might drain out the back. -She was not sure what was being done to fix the unit from leaking into her room. Second interview with the resident who resided in the room on 09/02/26 at 8:35pm revealed: -No one cleaned up the water from yesterday. -She knocked her pillows off the bed during her sleep and was upset her pillows were wet from the water on the floor. Interview with a housekeeper on 09/02/26 at 8:45am revealed: -He found out about the water leaking from the air conditioning unit in the first resident's room on the previous Friday (08/28/26). -He placed something under the front of the unit in an effort to encourage the water to drain out of the back instead of into the floor. -The Maintenance Director was on vacation at the time, was not available for repair, and just returned to work on 09/01/26. -He forgot to clean the water out of the floor when it was brought to his attention on 09/01/26 because he got busy. Interview with the Maintenance Director on 09/02/26 at 9:23am revealed: -The leaking water in the resident's bedroom floor had been going on for "a week or so". -He had tried different things but it had not helped and he was on vacation for 4 days, just returning yesterday (09/01/26). Interview with the Resident Care Coordinator on 09/01/26 revealed water on the floor of a	{D 079}		

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{D 079}	Continued From page 7 resident's room could cause the resident to slip and fall. b. Observation of a second resident room on 09/01/26 at 9:22am revealed: -Resident and survey staff continually swatted flies from their faces throughout the interview. -The resident who resided in the room coughed and 5-6 flies flew from his pants. -There were flies and brown residue on the ceiling and walls. -There was a trash can by the head of his bed that was full and included a used adult brief. -There was no liner in the can and the can was soiled with brown residue and stains as well as the wall behind the trashcan. Interview with the resident who resided in the second resident room on 09/01/26 at 9:22am revealed: -There were always a lot of flies in his room and they sometimes kept him awake at night. -The facility used to have a sticky fly strip hanging in his room but it got full and they took it down approximately 1 month prior. Interview with the second resident's hospice nurse on 09/01/26 at 9:35pm revealed the flies were always "terrible" in the resident's room. Observation of a third resident's room on 09/02/26 at 10:48am revealed there were 2 fly trap tapes hanging from the ceiling with numerous flies. Observation of a fourth resident's room on 09/02/26 at 10:49am revealed there was a fly trap tape hanging from the ceiling with flies adhered to the entirety of the trap.	{D 079}		

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{D 079}	Continued From page 8 Observation of a fifth resident on 09/02/26 at 11:08am revealed she was in the hallway by the nursing station chasing flies and swatting them with a fly swatter. Observation of a sixth resident's room on 09/01/26 at 9:47am revealed: -The bed linens were stained. -There was debris on the bed. -There were 2 pieces of molding on the floor beside her closet. Telephone interview with a local Environmental Health Inspector on 09/01/26 at 11:10am revealed: -The biggest concern in the facility during the inspection on 06/16/26 was the cleanliness of the facility. -There were numerous flies flying around especially in a residents' room. -There were residents' rooms that needed to be cleaned of debris, furniture and ceilings were not in good repair, and there was fecal matter as well as urine splattered in the toilets. Telephone interview with the facility's pest control technician on 09/02/26 at 10:17am revealed: -He treated the exterior of the facility every 2 months and his last visit was the previous week on either Wednesday or Thursday. -He treated for crawling insects and mice but did not do any treatment for flies. -The back door was constantly being opened and that door was by the kitchen so flies were drawn in. -Flies had sponging and sucking mouth parts that it uses to regurgitate on its food to liquefy it can soak up food. -Flies were unsanitary and could spread disease and cause food poisoning like botulism.	{D 079}		

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{D 079}	Continued From page 9 -The facility had air curtains at the front and back door but they were not used. -Turning on the air curtain would help tremendously with fly control since they created high air flow and pressure that prevented flies from entering when the door was opened. Interview with a housekeeper on 09/02/26 at 10:52am revealed: -He wondered why the air curtains were not used to prevent flies from entering the facility. -He sprayed fly spray and hung fly trap tape but it didn't help much since the doors were opened so often. Interview with the Resident Care Coordinator on 09/01/26 at 3:10pm revealed: -Housekeeping staff were expected to keep the rooms clean. -There were always flies in the facility because the doors were constantly being opened. -She did not know why the air curtains were not in use. Interview with the Administrator on 09/02/26 at 10:50am revealed: -The air curtains were operational but were not used. -She thought residents turned them off. -Housekeeping was responsible for ensuring the cleanliness of the facility and resident rooms but some residents would not let the staff clean their rooms. _____ The facility failed to ensure an environment clean and free of hazards was maintained for the residents related to water leaking into the floor of a resident's room, dirty bed linen on resident beds and swarming of flies throughout the facility including resident rooms. The facility's failure was	{D 079}		

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{D 079}	Continued From page 10 detrimental to the health and safety of the residents and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/11/26 for this violation.	{D 079}		
{D 253}	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications;	{D 253}		

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{D 253}	Continued From page 11 (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10) skin integrity; (11) memory, orientation and cognition; (12) vision and hearing; (13) speech and communication; (14) assistive devices needed; and (15) a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost.	{D 253}		

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{D 253}	Continued From page 12	{D 253}		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure an assessment was completed annually for 2 of 5 sampled residents (#1, #3).

The findings are:

1. Review of Resident #1's current FL-2 dated 03/18/26 revealed:
-Diagnoses included migraines, insomnia and anxiety.
-She was semi-ambulatory and continent of bowel and bladder.

Review of Resident #1's Resident Register revealed she was admitted on 04/02/24.

Review of Resident #1's care plan dated 03/13/25 revealed:
-Resident #1 used a walker to assist with mobility.
-Resident #1 required supervision with eating toileting. ambulation,stressing and transferring.
-Resident #1 required limited assistance from staff for bathing and grooming.
-She was very independent but sometimes required staff assistance with bathing.

Review of Resident #1's record revealed there was no updated assessment available for Resident #1.

Refer to interview with the Resident Care Coordinator (RCC) on 09/01/26 at 2:28pm.

Refer to interview with the Administrator on 09/01/26 at 2:25pm.

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{D 253}	Continued From page 13 2. Review of Resident #3's current FL-2 dated 07/08/26 revealed: -Diagnoses included fatigue, chronic obstructive pulmonary disease (COPD) and arthritis. -He was semi-ambulatory with the use of a walker. Review of Resident #3's care plan dated 04/17/25 revealed: -There was documentation that staff assisted him with bathing, shaving and dressing due to weakness and fatigue. -There were no level of assistance documented under the activities of daily living. Review of Resident #3's record revealed there was no updated assessment available for Resident #3. Interview with Resident #3 on 09/01/26 revealed he required assistance from staff for dressing and bathing. Refer to interview with the Resident Care Coordinator (RCC) on 09/01/26 at 2:28pm. Refer to interview with the Administrator on 09/01/26 at 2:25pm. _____ Interview with the Resident Care Coordinator (RCC) on 09/01/26 at 2:28pm revealed: -She was responsible for ensuring the assessments for residents were completed annually. -She made a list of the residents who needed an updated assessment but did not ensure they were done. Interview with the Administrator on 09/01/26 at	{D 253}		

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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 253}	Continued From page 14 2:25pm revealed: -The RCC reviewed the residents records and made a list of residents' assessments that were due. -She thought the RCC completed all the residents' assessments that were due. -She did not audit the residents' records herself and ensure the assessments were completed.	{D 253}		
{D 273}	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 1 of 3 sampled residents (#1) including failing to complete a referral for eye exam and follow-up on an order for occult blood. The findings are: Review of Resident #1's current FL-2 dated 03/18/26 revealed: -Diagnoses included migraines, insomnia and anxiety. -She was semi-ambulatory and continent of bowel and bladder. a. Review of Resident #1's primary care provider's (PCP) note dated 08/20/26 revealed: -Resident #1 was seen for an annual wellness visit. -There was an order for an eye exam. Review of Resident #1's record revealed there	{D 273}		

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	HAL043035	A. BUILDING: _____ B. WING _____	R 09/02/2026

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{D 273}	Continued From page 15	{D 273}		

was no documentation of an eye exam being completed.

Interview with Resident #1 on 09/02/26 at 9:16am revealed:
-She had cataract surgery in one eye approximately 3 years ago and had mentioned to her PCP that she may want to have the other eye done.
-She thought maybe that was why the eye exam was ordered.

Telephone interview with a representative for Resident #1's PCP on 09/02/26 at 9:29am revealed:
-She was a triage health care provider and could access Resident #1's PCP notes.
-Resident #1 had an eye exam in 2025.
-Resident #1 was ordered an eye exam on 08/20/26 as a routine exam which should be done annually.

Refer to interview with the Resident Care Coordinator (RCC) on 09/01/26 at 3:10pm.

Refer to interview with the Administrator on 09/02/26 at 11:50am.

b. Review of Resident #1's primary care provider's (PCP) note dated 08/20/26 revealed:
-Resident #1 was seen for an annual wellness visit.
-There was an order for fecal occult blood testing. (Fecal occult blood testing is a screening tool used to detect hidden blood in the stool which could indicate health issues including colorectal cancer.)

Review of Resident #1's record revealed there was no documentation of a fecal occult blood

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{D 273}	Continued From page 16 testing. Interview with Resident #1 on 09/02/26 at 9:16am revealed she did not know why an order for stool occult blood was ordered and was not having any problems with her stomach or bowels. Telephone interview with a representative for Resident #1's PCP on 09/02/26 at 9:29am revealed: -She was a triage health care provider and could access Resident #1's PCP notes. - Resident #1 was ordered fecal occult blood testing as a routine screening on 08/20/26. Refer to interview with the Resident Care Coordinator (RCC) on 09/01/26 at 3:10pm. Refer to interview with the Administrator on 09/02/26 at 11:50am. _____ Interview with the Resident Care Coordinator (RCC) on 09/01/26 at 3:10pm revealed: -She was responsible for reviewing PCP visit notes for new orders. -She overlooked the orders in the 08/20/26 visit note. Interview with the Administrator on 09/02/26 at 11:50am revealed: -The RCC was responsible for ensuring orders were carried out. -PCP visit notes should be read through for new orders once they are received. -There was no process for the facility to complete chart audits for new orders and the facility relied on quarterly pharmacy reviews however the pharmacy audits did not include orders for appointments and labs.	{D 273}		

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D 366	Continued From page 17	D 366		
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 the medication aide (MA) observed 1 of 3 sampled residents (#1) take their medications that were left on the resident's nightstand in their room. The findings are: Review of Resident #1's current FL-2 dated 03/18/26 revealed: -Diagnoses included migraines, insomnia and anxiety. -She was semi-ambulatory and continent of bowel and bladder. -There was an order for buspirone (a medication used to treat anxiety) 10mg to be administered twice daily at 7:00am., and 8:00pm. -There was an order for ferrous sulfate (a medicaiton used to treat low iron levels in the blood) 325mg to be administered daily at 8:00am. -There was an order for ibuprofen (a medication used to treat pain) 800mg to be administered	D 366		

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D 366	Continued From page 18	D 366		

three times daily at 7:00am., 2:00pm and 8:00pm.
-There was an order for magnesium oxide (a medication used to treat constipation, heartburn or used as a dietary supplement) 400mg to be administered each day at 7:00am.
-There was an order for methadone (a long acting synthetic opioid medication used to treat severe chronic pain or opioid use disorder) 10mg, 7 and one half tablets to be administered twice daily at 7:00am and 7:00pm.
-There was an order for Movantik (a medication used to treat opioid induced constipation) 25mg to be administered each day at 7:00am.
-There was an order for Omeprazole (a medicaiton used to treat acid reflux) 40mg to be administered twice daily at 7:00am and 8:00pm.
-There was an order for Qulipta (a medication used to prevent migraine headache) 60mg to be administered each day at 7:00am.
-There was an order for promethazine (a medicaiton used to treat nausea) 25mg to be administered every 6 hours and scheduled for 12:00am, 6:00am., 12:00pm and 6:00pm.
-There was an order for nicotine (nicotine replacement used to assist people with smoking cessation) 21 mg patch to be applied each day at 7:00am.

Observation of Resident #1's room on 09/01/26 at 9:01am revealed:
-Resident #1 was sitting on her bed in the dark upon entrance.
-Resident #1 had a medication cup that contained 9 pills in her hand.
-There was an empty medicine cup in her lap.
-There was an unopened nicotine patch labeled 21 mg on her bed.
-There was a second unopened nicotine patch labeled 21 mg on top of her air conditioning unit.

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D 366	Continued From page 19 Interview with Resident #1 on 09/01/26 at 9:01am revealed: -The medication aide (MA) brought her medications to her room that morning and the empty medication cup had contained her methadone. -She had already taken her methadone and the remainder of her morning medications were in the cup she still held. -She normally woke up early and went to the medication cart to take her medications but she slept in that morning. -She would put the nicotine patch on if she needed it later but was doing well without it. Review of Resident #1's electronic medication administration record (eMAR) for September 2026 revealed: -There was an entry for buspirone 10mg to be administered twice daily at 7:00am., and 8:00pm. -There was documentation buspirone 10mg was administered at 7:00am. -There was an entry for ferrous sulfate 325mg to be administered daily at 8:00am. -There was documentation ferrous sulfate 325mg was administered at 8:00am. -There was an entry for ibuprofen 800mg to be administered three times daily and scheduled 7:00am., 2:00pm and 8:00pm. -There was documentation ibuprofen 800mg was administered at 7:00am. -There was an entry for magnesium oxide 400mg to be administered each day and scheduled for 7:00am. -There was documentation magnesium oxide 400mg was administered at 7:00am. -There was an entry for methadone 10mg, 7 and one half tablets to be administered twice daily and scheduled for 7:00am and 7:00pm -There was documentation methadone 10mg, 7	D 366		

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D 366	Continued From page 20	D 366		

and one half tablets was administered at 7:00am.
-There was an entry for Movantik 25mg to be administered each day and scheduled for 7:00am.
-There was documentation Movantik 25mg was administered at 7:00am.
-There was an entry for Omeprazole 40mg to be administered twice daily and scheduled for 7:00am and 8:00pm.
-There was documentation Omeprazole 40mg was administered at 7:00am.
-There was an entry for Qulipta 60mg to be administered each day and scheduled for 7:00am.
-There was documentation Qulipta 60mg was administered at 7:00am.
-There was an entry for promethazine 25mg to be administered every 6 hours and scheduled for 12:00am, 6:00am., 12:00pm and 6:00pm.
-There was documentation promethazine 25mg was administered at 6:00am.
-There was an entry for nicotine 21 mg patch to be applied each day at 7:00am.
-There was documentation nicotine 21 mg patch was applied at 7:00am..

Interview with a MA on 09/01/26 at 11:45am revealed:
-Resident #1 usually went to the medication cart to take her medications but she took the medications to her room and had to wake her up to administer her medications that morning on 09/01/26.
-She administered Resident #1's 6:00am, 7:00am and 8:00am medications all at the same time.
-She thought she saw Resident #1 take her medication that morning but the light was off when she administered them.

Telephone interview with a representative for

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D 366	Continued From page 21 Resident #1's PCP on 09/02/26 at 9:29am revealed: -She was a triage health care provider and could access Resident #1's PCP notes. -She did not see residents in person at the facility. -The PCP that saw residents at the facility was no longer available and the facility residents were in the process of reassignment. -Medications should not be left at the bedside for residents to take later. -Medications would not work as effectively if they were not taken as prescribed. Interview with the Administrator on 09/02/26 at 11:50am revealed MAs were expected to observe residents taking their medication to ensure they took them as ordered.	D 366		