STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043031	A. BUILDING: _____ B. WING _____	02/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE CARE ASSISTED LIVING II	431 JUNNY ROAD ANGIER, NC 27501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 02/25/20 through 02/26/20.	D 000		
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 observation, record review and interviews the facility failed to ensure referral and follow up to meet acute healthcare needs for 1 of 3 sampled residents (#5) regarding a podiatry appointment and an ear, nose and throat (ENT) appointment. The findings are: Review of Resident #5's current FL2 dated 12/05/19 revealed diagnoses included Parkinson's disease, hypertension, sleep apnea, obesity and mixed hyperlipidemia. a. Review of Resident #5's physician's office visit report dated 1/02/20 revealed: -There was an order written by the Primary Care Provider (PCP) for a referral to a podiatrist for toenail cutting. -There was a hand-written note at the top of the	D 273		

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D 273	Continued From page 1 paper that the appointment was scheduled for 2/11/20. Review of the facility's resident appointment calendar revealed there was an entry on 2/11/20 documenting Resident #5's podiatry appointment. Interview with a Personal Care Aide (PCA) on 2/25/20 at 12:15pm revealed: -An entry in the facility's resident appointment calendar documented Resident #5's podiatry appointment on 2/11/20. -Resident #5 was transported to the podiatrist appointment, but proper paperwork was incomplete, so he was not seen on 2/11/20. -The missed appointment had not been rescheduled. Interview with the Medication Aide (MA) on 2/25/20 at 12:48pm revealed: -MAs were responsible for processing physician orders on the day they were received. -There was a filing slot, which they referred to as a "hold box", in the office where paperwork was placed that still needed to be completed. -When a MA started their shift, they checked the "hold box" to see if any orders needed to be processed. -Once an order was completely processed, the word "file" was written on the top of the paper. -The order would then be placed in a different box so staff knew the paper needed to be filed in the resident's record. -The MA on duty the day after the missed appointment would have been responsible for rescheduling the appointment but there was no paperwork in the "hold box" so the appointment was never rescheduled. Observation of Resident #5's feet with a PCA	D 273		

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D 273	Continued From page 2	D 273		

present on 2/25/20 at 3:07pm revealed his toenails were long and jagged.

Telephone interview with the facility's PCP on 2/25/20 at 3:26pm revealed:
-She was unaware that the scheduled podiatry appointment had not been completed.
-After she wrote a medical order, she "usually" checked on it the following week when she came to the facility.
-Resident information was discussed with the MA's during her weekly visits to the facility and she would have expected to be told about a missed appointment at that time.

b. Review of Resident #5's physician's office visit report dated 2/06/20 revealed:
-There was an order written by the PCP for an ENT appointment to remove earwax from both ears and to evaluate for dizziness and lightheadedness.
-There was no note on the report documenting a pending appointment.
-The word "file" was not hand-written at the top of the paper.

Interview with a MA on 2/25/20 at 12:48pm revealed:
-MAs were responsible for processing physician orders on the day they were received.
-She did not remember if she called to schedule the ENT appointment or not.
-She did not work the day after the order was written so she would not have been the MA to follow-up and confirm the appointment had been scheduled.

Telephone interview with the facility's PCP on 2/25/20 at 3:26pm revealed:
-She was unaware that an appointment for the

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D 273	Continued From page 3	D 273		

ENT had never been scheduled.
-Resident #5 had complained of being dizzy and lightheaded and an ENT consult was needed to determine if that was a side effect of impacted earwax.
-After she wrote an order, she "usually" checked on it the following week when she came to the facility.
-Resident #5 needed to have the ENT appointment scheduled because multiple treatments at the facility to remove the impacted earwax had been unsuccessful and the cause of dizziness needed to be determined.

Interview with the Administrator on 2/26/20 at 2:00pm revealed:
-She did not know the podiatry paperwork was incomplete and Resident #5 had not been seen on 2/11/20.
-She was unaware that Resident #5 had an order to be seen by an ENT.
-Because the word "file" was not written at the top of the ENT order, that indicated the paperwork had not been processed properly.
-The MA's were responsible for processing all paperwork for physician orders.
-There was a "hold box" in the office where paperwork was placed that needed to be completed.
-When a MA started their shift, they should check the "hold box" to see if any orders needed to be processed.
-Once an order was completely processed, the word "file" was written on the top of the paper and placed in a different box so staff knew the paper could then be placed in the resident's record.
-A Resident Care Coordinator (RCC) was usually responsible for auditing order processing procedures but the facility had been without that position since October 2019.

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D 273	Continued From page 4 -She had not been auditing order processing procedures since the RCC position was vacated. -It was her expectation that staff followed proper procedures. Based on observation and interview it was determined Resident #5 was not interviewable.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to serve therapeutic diets as ordered for 2 of 3 residents related to a diabetic diet (Resident #1 and #3) and did not provide a supplemental sugar free beverage for 1 of 1 resident (Resident #1). The findings are: 1. Review of Resident #1's current FL-2 dated 11/05/19 revealed: -Diagnoses included acute kidney injury, interstitial lung disease, history of stroke and diabetes. -There was nothing documented in the dietary information section for Resident #1. Record review of Resident #1's previous FL-2	D 310		

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dated 10/25/19 revealed:
-There was a physician's order for a diabetic diet.
-There was a physician's order for a supplemental sugar free beverage, though the order did not specify how often.

Interview with the cook on 02/25/20 at 9:56am revealed:
-She only used the regular menu, not the therapeutic diet menu.
-All residents were served the same meals, but they did have sugar free condiments available.

Observation of Resident #1 at the lunch meal on 02/25/20 at 12:30pm revealed:
-He was eating the same meal as all the other residents.
-His meal included baked chicken, noodles, green beans, dinner roll, ambrosia fruit salad and tea.
-He did not have a supplemental sugar free beverage at this meal.

Interview with Resident #1 on 02/26/20 at 8:30am revealed:
-He was a diabetic.
-The staff checked his blood sugar every morning.
-He takes a pill to treat his diabetes but is not on insulin.
-His "diet is no different than anyone else's."
-He had not received a sugar free supplemental beverage since coming to the facility.

Interview with the Co-Administrator on 02/26/20 at 12:15pmand 3:15pm revealed:
-The Medication Aide (MA) was responsible for sending any orders to the pharmacy when a resident is admitted to the facility.
-The MA was supposed to let her know what a

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new resident's diet was when he or she entered the facility.
-She documented the order on the dietary sheet and sent it to the dietary staff, so they know what diet or special supplement a new resident was on.
-She was not aware Resident #1 was supposed to be on a supplemental sugar free beverage or a diabetic diet.
2. Review of Resident #3's undated FL2 revealed:
-The admission date was documented as 1/08/20.
-Diagnoses included diabetes, congestive heart failure and coronary artery disease.
-There was a diet order for reduced concentrated sweets.

Observation of the therapeutic diet list posted in the kitchen on 2/25/20 at 9.56am revealed the list did not include Resident #3.

Observation of the lunch meal service on 2/25/20 at 12:30pm revealed:
-Resident #3's meal consisted of baked chicken, noodles, green beans, dinner roll and ambrosia salad.
-All meal plates served at lunch contained the same items and the same portion sizes.

Interview with the cook on 2/25/20 at 9:56am revealed:
-She had a menu book available for reference which included regular menus and therapeutic diet menus.
-She only referenced the regular menu and did not reference the therapeutic diet menus.
-Residents on a diabetic diet were served the same food but they had sugar free condiments.
-She received an updated diet list from the Administrator when new residents were admitted.

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D 310	Continued From page 7 -She did not have Resident #3 on her list as needing a diabetic diet. Interview with Resident #3 on 2/26/20 at 3:45pm revealed: -She had diabetes and needed to limit carbohydrate intake. -She received the same food as everyone else in the building. -She had never asked for anything different because she thought the staff knew she was diabetic. Interview with Administrator #2 on 2/26/20 at 3:30pm revealed: -She ordered and purchased all food for the facility and ordered sugar free items for residents who had diabetic diet orders. -She did not realize Resident #3 had orders for a diabetic diet. -She was responsible for keeping the kitchen staff informed as to the current diet orders. -She expected the kitchen staff to follow diet orders as written.	D 310		
D 329	10A NCAC 13F .0907(a)(b) Respite Care 10A NCAC 13F .0907 Respite Care (a) For the purposes of this Subchapter, respite care is defined as supervision, personal care and services provided for persons admitted to an adult care home on a temporary basis for temporary caregiver relief, not to exceed 30 days. (b) Respite care is not required as a condition of licensure. However, respite care is subject to the requirements of this Subchapter except for Rules .0702, .0704(b), .0801, .0802 and .1201. This Rule is not met as evidenced by:	D 329		

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D 329	Continued From page 8 Based on observations, record review and interviews the facility failed to discharge 1 of 3 sampled residents admitted for respite care within 30 days (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 11/05/19 revealed: -Resident #1 was documented as rest home level of care. -Diagnoses included acute kidney injury, interstitial lung disease, history of stroke and diabetes. Interview with Resident #1 on 02/26/20 at 8:30am revealed: -He was unable to remember how long he had been in the facility. -He was not sure when he was admitted if he was respite care or not, but he lived at the facility permanently "now". -He had been homeless and had several medical issues causing him to require a hospitalization and the Social Worker at the local hospital made arrangements for him to come to the facility. Review of Resident #1's facility respite admission paperwork revealed: -His admission date to the facility was 10/26/19. -The Resident Register had not been completed. Interview with the Co-Administrator on 02/26/20 at 3:05pm revealed: -The Social Worker at the local hospital had been giving them "verbal ok's" to prolong Resident #1's 30 days of respite care. -They had nothing in writing to verify the Social Worker gave the "verbal ok" to continue to provide respite care for Resident #1.	D 329		

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D 329	Continued From page 9 Interview with the Social Worker (SW) at the local hospital for Resident #1 on 02/26/20 at 3:34pm revealed: -There was an agreement between the hospital and the facility to assist individuals who need medical respite for 30 days. -If she knew the individual would be there for longer than 30 days, she would tell the facility the individual would be there for several weeks and would not give a discharge date. -Resident #1 had been in the facility longer than 30 days and was being considered for permanent placement. Interview with Co-Administrator #2 on 02/26/20 revealed: - "Most" of the respite residents the facility admitted were chronically homeless who had been hospitalized for a medical condition and were recovering at the facility. -They were respite residents instead of permanent assisted living residents because there was no funding for them. -"We made sure all residents would qualify for assisted living based on their diagnoses and daily care needs when we accepted them as respite residents." -She was not aware she could not have the 30-day respite extended for Resident #1. -Resident #1 was in process of transitioning from a respite resident to an assisted living resident.	D 329		
D 333	10A NCAC 13F .0907 (f) Respite Care 10A NCAC 13F .0907 Respite Care (f) Upon admission of a respite care resident into the facility, the facility shall assure that the	D 333		

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D 333	Continued From page 10 resident has a current FL-2 and been tested for tuberculosis disease according to Rule .0703 of this Subchapter and that there are current physician orders for any medications, treatments and special diets for inclusion in the respite care resident's record. The facility shall assure that the respite care resident's physician or prescribing practitioner is contacted for verification of orders if the orders are not signed and dated within seven calendar days prior to admission to the facility as a respite care resident or for clarification of orders if orders are not clear or complete. This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure respite residents FL2's were dated within seven calendar days for 1 of 3 sampled residents (#3). The findings are: Review of Resident #3's current FL2 revealed: -The FL2 was not dated when the physician signed it. -The FL2 listed an admission date of 1/08/20. Interview with Administrator #1 on 2/26/20 at 11:08am revealed: -She knew the FL2 was supposed to be signed and dated by the physician. -She was not aware the FL2 had not been dated. -The Resident Care Coordinator (RCC) was responsible for this paperwork but that position had been vacant since October 2019. -She had assumed the RCC duties when the position was vacated.	D 333		

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D 335	Continued From page 11	D 335		
D 335	10A NCAC 13F .0907 (h) Respite Care 10A NCAC 13F .0907 Respite Care (h) The respite care resident's record shall include a copy of the signed respite care contract; the FL-2; the assessment and care plan; documentation of a tuberculosis test according to Paragraph (f) of this Rule; documentation of any contacts (office, home or telephone) with the resident's physician or other licensed health professionals from outside the facility; physician orders; medication administration records; a statement, signed and dated by the resident or responsible person, indicating that information on the home as required in Rule .0704(a) of this Subchapter has been received; a written description of any acute changes in the resident's condition or any incidents or accidents resulting in injury to the respite care resident, and any action taken by the facility in response to the changes, incidents or accidents; and how the responsible person or his designated representative can be contacted in case of an emergency. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure the respite care resident's records included a copy of the signed respite care contract for 3 of 3 residents (Residents #1, #2 and #3), an assessment or Resident Register for 2 of 3 residents (Residents #1 and #2) and care plans for 3 of 3 residents (Residents #1, #2 and #3). The findings are:	D 335		

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D 335	Continued From page 12 1. Review of Resident #1's record revealed: -The admission date documented on the FL-2 was 10/26/19. -The care plan documented Resident #1's name and the name of the facility but no other information. -The record did not contain a respite admission contract. -The record did not contain an assessment or Resident Register. Refer to interview with the Co-Administrator at 11:08am on 02/26/20. 2. Review of Resident #2's record revealed: -The admission date documented on the FL-2 was 02/04/20. -The care plan did not have documentation of assistance needed with activities of daily living, the signature and date of the assessor and the signature and date of the physician. -The record did not contain a respite admission contract. -The record did not contain an assessment or resident register. Refer to interview with the Co-Administrator at 11:08am on 02/26/20. 3. Review of Resident #3's record revealed: -The admission date documented on the FL2 was 1/08/20 -It contained a partially completed care plan. -The care plan was signed and dated by Resident #3 on 02/04/20. -The care plan was not signed or dated by the physician. -The record did not contain a respite admission contract. -The record did not contain a resident register.	D 335		

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D 335	Continued From page 13 Refer to interview with the Co-Administrator at 11:08am on 02/26/20. _____ Interview with the Co-Administrator at 11:08am on 02/26/20 revealed: -When a resident was admitted to respite care, all the paperwork was to be completed within 48 hours. -The Medication Aide (MA) on shift when a new resident arrived at the facility should start the paperwork. -If the paperwork was not completed by the admitting MA at the end of her shift, the admitting MA was supposed to pass on the information to the oncoming MA so the paperwork could be completed. -She was not aware the assessment or Resident Register and care plans were missing for the respite residents. -She thought the consent for authorization of respite served as the contract for respite. -The Resident Care Coordinator (RCC) was responsible for all the admissions and following up with the MAs to ensure the paperwork was complete, but the RCC left in October 2019 and had not been replaced. -She was responsible for following up within 48 hours for new admissions to ensure all the paperwork was complete for the residents records.	D 335		
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	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABSOLUTE CARE ASSISTED LIVING II	431 JUNNY ROAD ANGIER, NC 27501

(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
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by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews the facility failed to administer medications as ordered for 2 of 3 sampled residents for medications to treat elevated blood pressure (Resident #5) and medication used to treat pain (Resident #4).

The findings are:

1. Review of Resident #5's current FL2 dated 12/05/19 revealed:
-Diagnoses included Parkinson's disease, hypertension, sleep apnea, obesity and mixed hyperlipidemia.
-There was an order for 25mg metoprolol succinate ER (extended release) (used to treat high blood pressure) to be administered daily.
-There was an order for 50 mg metoprolol succinate ER to be administered daily.
-There was an order for 30mg lisinopril (used to treat high blood pressure) to be administered twice daily.

Review of Resident #5's January 2020 electronic Medication administration record (eMAR) revealed:
-There was an entry for 25mg metoprolol succinate ER to be administered daily at 8am.
-There was an entry for 50 mg metoprolol succinate ER to be administered daily at 8am.
-There was an entry for 30mg lisinopril to be administered twice daily at 8am and 8pm.
-The 25mg metoprolol succinate ER was

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D 358	Continued From page 15 documented as administered at 8am for 31 of 31 opportunities. -The 50mg metoprolol succinate ER was documented as administered at 8am for 31 of 31 opportunities. -The 30mg lisinopril was documented as administered at 8am and 8pm for 61 of 62 opportunities. -Blood pressure checks and pulse were documented as obtained at 8am and 8pm on 61 of 62 opportunites. Review of Resident #5's February 2020 eMAR revealed: -There was an entry for 25mg metoprolol succinate ER to be administered daily at 8am. -There was an entry for 50 mg metoprolol succinate ER to be administered daily at 8am. -There was an order for 30mg lisinopril to be administered twice daily at 8am and 8pm. -The 25mg metoprolol succinate ER was documented as administered at 8am for 24 of 25 opportunities. -The 50mg metoprolol succinate ER was documented as administered at 8am for 24 of 25 opportunities. -The 30mg lisinopril was documented as administered at 8am and 8pm for 47 of 49 opportunities. -Blood pressure checks and pulse were documented asobtained at 7am and 7pm on 39 of 49 opportunites. -Blood pressure checks and pulse were documented as obtained at 8am and 8pm on 47 of 49 opportunites. Observation of medication on hand on 2/25/20 at 12:45pm revealed: -The 25mg metoprolol succinate ER was available for administration.	D 358		

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-The 50mg metoprolol succinate ER was available for administration.
-The 30mg lisinopril was available for administration.

Review of Resident #5's physician office visit report dated 2/6/20 revealed:
-There was an order to discontinue 8am administration of lisinopril and metoprolol.
-There was an order to change the time of administration of lisinopril and metoprolol from 8am and 8pm to 7am and 7pm.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 2/25/20 at 2:18pm revealed:
-The pharmacy received the faxed medication order on 2/6/20 at 3:48pm.
-The order was incomplete as written and needed clarification, so the pharmacy was unable to dispense the medication.
-The pharmacy "usually" contacted the facility or the physician for clarification when they received incomplete orders.
-The notes at the pharmacy did not indicate who was contacted for clarification.
-The pharmacy and "some" facility employees could edit the eMAR.

Telephone interview with Resident #5's Primary Care Provider (PCP) on 2/25/20 at 3:26pm revealed:
-The facility nor the pharmacy had ever contacted her for clarification of the medication orders written on 2/6/20.
-She wished the facility had noticed this and contacted her about this earlier.
-The metoprolol was intended to be a daily medication, not a twice daily administration as she had written.

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D 358	Continued From page 17 -She wanted Resident #5 to have his blood pressure medications earlier in the day because he had been experiencing elevated blood pressure readings and she was trying to determine if an earlier medication administration time would improve his readings. -Not having the medication administration time changed did not pose a significant health risk to Resident #5 but because the medication times had not been changed as she had ordered she was now unable to make an informed evaluation. Interview with the Medication Aide (MA) on 2/25/20 at 12:48pm revealed: -MAs were responsible for processing physician orders on the day they were received. -If an order needed to be clarified, the MA was responsible for getting that clarification. -There was a filing slot, which they referred to as a "hold box", in the office where paperwork was placed if it had not been completed the first day. -When a MA started their shift, they checked the "hold box" to see if any orders needed to be processed. -Once an order was completely processed and a medication delivery was confirmed, the word "file" was written on the top of the paper. -The order was then placed in a different box so staff knew the paper could then be placed in the resident's record. -When a medication was delivered by the pharmacy, the MA was responsible for ensuring the MAR was updated. -She was working the day the order was written so she would have been the MA to fax the order to pharmacy. -She remembered faxing the order but did not remember if the order process had been completed. -She did not work the following day and therefore	D 358		

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would not know if the order process had been completed.
-MA were not allowed to make changes to the MAR.

Interview with the Administrator on 02/26/20 at 2:00pm revealed:
-The MA's were responsible for processing all paperwork for physician orders.
-There was a "hold box" in the office where paperwork was placed that needed to be completed.
-When a MA started their shift, they should check the "hold box" to see if any orders needed to be processed.
-Once an order was completely processed, the word "file" was written on the top of the paper and placed in a different box so staff knew the paper could then be placed in the resident's record.
-Because paperwork had not been processed properly, the order change did not occur.

2. Review of Resident #4's current FL-2 dated 03/07/19 revealed diagnoses included diabetes, high cholesterol and iron deficiency.

Review of physician's orders dated 01/23/20 revealed an order to change Resident #4's acetaminophen (used to treat pain) 325 milligrams (mg) every 6 hours as needed to 650mg every 12 hours for arthritis.

Interview with Resident #4 on 02/25/20 at 12:50PM revealed:
-He had "some" pain in his hips and legs every day.
-Sometimes his pain was bad in the morning, but if he got up and moved around it would help.
-He thought the pain was from arthritis.
-He asked the staff for pain medication some of

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the time, but other times he chose not to say anything.
-He would prefer to have daily medication daily to help treat the pain in his hips and legs.

Review of Resident #4's Medication Administration Record (MAR) for January 2020 revealed:
-There were entries for acetaminophen 325mg tablet every 6 hours as needed for pain.
-During January 2020 Resident #4 was administered acetaminophen on 13 different occasions.
-There was no entry for acetaminophen 650mg to be administered every 12 hours.

Review of Resident #4's MAR for February 2020 revealed:
-There were entries for acetaminophen 325mg tablet every 6 hours as needed for pain.
-During February 2020 Resident #4 was administered acetaminophen on 10 different occasions.
-There was no entry for acetaminophen 650mg to be administered every 12 hours.

Interview with the Pharmacist from the facilitys contracted pharmacy on 02/25/20 at 2:20pm revealed:
-The only order they had received for Resident #4 was for acetaminophen 325milligrams (mg) 2 tablets every 8 hours as needed for pain.
-The pharmacy had not received an order for scheduled acetaminophen to be administered to Resident #1.

Interview with the Medication Aide (MA) on 02/25/20 at 2:30pm revealed:
-She had faxed the order for Resident #4's acetaminophen to be changed from as needed to

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D 358	Continued From page 20 scheduled to the pharmacy. -She did not know why they didn't have the order. -She had not followed up with a call to the pharmacy to verify the order had been received. Interview with the facility physician regarding Resident #4 on 02/25/20 at 3:40pm revealed: -The facility staff had not made her aware Resident #1 was not taking acetaminophen as scheduled. -No harm occurred to Resident #4 for not taking the acetaminophen as ordered. -She expected the facility staff to follow her orders and call her if they had any questions about an order.	D 358		