

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 000	Initial Comments The Adult Care Licensure Section conducted annual survey on 05/04/15 and 02/05/15.	C 000		
C 202	<p>10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination</p> <p>10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review the Adult Care Home failed to assure 1 of 4 sampled residents (Resident #4) had completed tuberculin test as required by the Commission for Health Services.</p> <p>The findings are:</p> <p>Observation on 02/04/15 at 11:40 am revealed: -Six residents were present at the facility. -Three residents were sitting in the common living room. -Two residents were in their bedroom. -One resident was in the bathroom.</p> <p>Interview on 02/04/15 at 11:50 am with the Supervisor-in-Charge (SIC) revealed: -Only 5 residents lived at the facility. -The resident identified as Resident #4 did not</p>	C 202		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
--	-------	-----------

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 202	<p>Continued From page 1</p> <p>live at the facility.</p> <ul style="list-style-type: none"> -The resident was visiting another resident at the facility. -Resident #4 was dropped off every morning. -She stayed at the facility for a couple of hours, and was picked up by someone. <p>Confidential interviews with four residents revealed:</p> <ul style="list-style-type: none"> -There was an emergency and Resident #4 had to come to the facility. -Resident #4 live at the facility since Monday, February 2, 2015. -Resident #4 ate breakfast, lunch and dinner with other residents at the facility. -Resident #4 slept in bedroom #3. -Facility staff gave Resident #4 medications daily. <p>A request by the surveyor for Resident #4's record revealed:</p> <ul style="list-style-type: none"> -There was no record at the facility. -No documentation of the resident's diagnoses, disorientation status, ambulation, TB testing, diet order, health care status, medication review, LHPS review, assessment and care plan or mental health. <p>Interview on 02/04/15 at 12:10 pm with Resident #4 revealed:</p> <ul style="list-style-type: none"> -She lived at another family care home owned by the Administrator. -On Monday, February 2, 2015, there was an emergency at another family care home and no staff was available, so she had to move this facility. -She was not given an option of staying at her family care home, but told it was an emergency and there was no staff to stay with her at the family care home where she lived. -She slept in room #3. 	C 202		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 202	<p>Continued From page 2</p> <ul style="list-style-type: none"> -She ate breakfast, lunch, and dinner at the facility. -Staff administered her medications three times daily. -The Administrator told her that she was leaving this facility on Friday, February 6, 2015, and returning to the family care home where she lived. <p>Second interview on 02/04/15 at 12:40 pm with the SIC revealed:</p> <ul style="list-style-type: none"> -She did not tell the truth in her first interview for fear of getting in trouble. -Resident #4 lived at the facility since Monday, February 2, 2015. -There was an emergency with staff at another facility, and there was no one to watch Resident #4, so the resident was brought to the facility to live. -Resident #4 ate all meals at the facility. -There was no record or documentation brought with Resident #4 to the facility. -She administered Resident #4 medications three times daily, according to the instructions on the pharmacy printed label. -She did not document the administering of medications because there was no medication administration record available. -She did not have any orders for Resident #4's medications and was unaware of medication orders. -She had not clarified the orders with the physician or pharmacy to ensure the medications were current orders and dosage was correct. <p>Interview on 02/05/15 at 2:25 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -On Monday, February 2, 2015 there was an emergency, where a staff at another facility got sick. 	C 202		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 202	<p>Continued From page 3</p> <ul style="list-style-type: none"> -She took the staff and two residents at the home where Resident #4 lived and sent them to the family care home (#9), where the staff got sick. -The reason she moved Resident #4 and other residents out of their home was that home had no open beds to move in residents from home #9. -It was easier to move the staff person and four residents (Resident #4) to another home temporarily. -Residents were moved as follows: -One resident to family care home #7, Resident #4 to this home, and two residents went to home #9 where she needed the staff person. -She did not have time to search for another staff because she was leaving town on Wednesday, February 4, for a funeral. -She did not ask residents if they wanted to move, "I was rushed and confused", thinking of ways to serve residents at all four homes. -The thought never occurred to send Resident #4's MARs and record with the resident to this home. 	C 202		
C 330	<p>10A NCAC 13G .1004(a) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a safe and</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 330	<p>Continued From page 4</p> <p>effective system for the preparation and administration of medications in accordance with the rules of this subchapter was in place to ensure accurate medication administration of Cogentin, Ferrous Sulfate, Abilify, and Lamotrigine for 1 of 4 residents (Resident #4).</p> <p>The findings are:</p> <p>Observation on 02/04/15 at 1:40 pm of Resident #4's medications on hand at the facility revealed:</p> <ul style="list-style-type: none"> -Four containers of bubble packed medications. -Each container had Resident #4's name, dispensing date, name of the medications, strength, and dosage. -One bubble pack had Cogentin (psychiatric used to treat nerves) 1mg twice daily, Ferrous Sulfate (used to treat iron deficiency) 325mg three times daily. -A second bubble pack had Ferrous Sulfate 325mg three times daily, and Lamotrigine (used to treat bipolar) 100mg once daily. -A third bubble pack had Abilify (used to treat schizophrenia related symptoms) 20mg once daily. -A fourth bubble pack has Ferrous Sulfate 325mg three times daily. <p>Interview on 02/04/15 at 12:10 pm with Resident #4 revealed:</p> <ul style="list-style-type: none"> -She lived at another family care home owned by the Administrator. -On Monday, February 2, 2015, due to an emergency with staff at another family care home she was brought to this facility to live. -She was not asked if she was okay moving to another family care home temporarily, but staff told her that she would return back to her home on Friday (February 6, 2015). -Staff at this home administered her medications 	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 330	<p>Continued From page 5</p> <p>three times daily.</p> <p>-She was not sure of medications ordered, she took what staff gave her.</p> <p>-She did not observe staff document the administration of her medications.</p> <p>Interview on 02/04/15 at 12:40 pm with the Supervisor-in-Charge (SIC) revealed:</p> <p>-Resident #4 was brought to the facility on Monday, February 2, 2015 by the Administrator.</p> <p>-The Administrator gave her four bubble packages of medications in a plastic shopping bag.</p> <p>-She knew how to administer Resident #4's medications because she followed instructions on pharmacy printed label.</p> <p>-She administered Resident #4's medications three times daily at 8:00 am, 2:00 pm and 8:00 pm.</p> <p>-There was no MARs given to document the administration of Resident #4's medications.</p> <p>-Once daily she called the staff person from Resident #4's home, now at home #9 and verbally told that staff she administered Resident #4's medication.</p> <p>-She did not see staff document administration of Resident #4's medications.</p> <p>-She was unaware if staff accurately or truly documented the administration of Resident #4's medications.</p> <p>Interview on 02/05/15 at 2:25 pm with the Administrator revealed:</p> <p>-She brought Resident #4 to the facility on Monday, February 2, 2015.</p> <p>-She did not bring Resident #4's record or MARs to the home with the resident.</p> <p>-Resident #4's record and MARs were taken to another family care home (not where Resident #4 lived).</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 330	<p>Continued From page 6</p> <p>-She did not give instructions for staff at that home to document the administration of Resident #4's medications.</p> <p>-It was the facility's policy that medications were to be administered in accordance with physician's orders and instructions.</p> <p>-It was also the facility's policy that orders for medication administration be kept on site where the resident resided.</p> <p>-Not having Resident #4's MARs and records available for staff was her fault because when the staff got sick on Monday she did not think to bring the record with the resident.</p> <p>-Resident #4 had a TB test and it was in her record at another home.</p>	C 330		
C 341	<p>10A NCAC 13G .1004 (i) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration</p> <p>(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.</p> <p>This Rule is not met as evidenced by: Based on observation, interviews and record review, the facility failed to assure all medications administered to residents were documented as administered immediately following administration of the medication for 1 of 4 sampled residents (Resident #4).</p>	C 341		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 341	<p>Continued From page 7</p> <p>The findings are:</p> <p>Observation on 02/04/15 at 1:40 pm of Resident #4's medications on hand at the facility revealed:</p> <ul style="list-style-type: none"> -Four containers of bubble packed medications. -Each container had Resident #4's name, dispensing date, name of the medications, strength, and dosage. -One bubble pack had Cogentin 1mg twice daily, Ferrous Sulfate 325mg three times daily. -A second bubble pack had Ferrous Sulfate 325mg three times daily, and Lamotrigine 100mg once daily. -A third bubble pack had Abilify 20mg once daily. -A fourth bubble pack has Ferrous Sulfate 325mg three times daily. <p>Interview on 02/04/15 at 12:10 pm with Resident #4 revealed:</p> <ul style="list-style-type: none"> -She lived at another family care home owned by the Administrator. -On Monday, February 2, 2015, due to an emergency with staff at another family care home she was brought to this facility to live. -She was not given the option of staying at her home because the staff person was sent to another home (#9). -She was not asked if she was okay moving temporarily to another home. -She did what she was told to do and was okay with the arrangement, because it was temporarily. -The Administrator told her that she would return to her home on Friday (February 6, 2015). -Staff at this home administered her medications three times daily. -She was not sure of medications ordered, she took what staff gave her. -She did not observe staff document the administration of her medications. 	C 341		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 341	<p>Continued From page 8</p> <p>Interview on 02/04/15 at 12:40 pm with the Supervisor-in-Charge (SIC) revealed:</p> <ul style="list-style-type: none"> -Resident #4 was brought to the facility on Monday, February 2, 2015 by the Administrator. -The Administrator gave her four bubble packages of medications. -The Administrator did not give her medication administration records (MARs). -She administered Resident #4's medications three times daily at 8:00 am, 2:00 pm and 8:00 pm. -She administered Resident #4's medications according to the pharmacy printed instructions on the label. -It was the facility's policy for residents residing in the home to have orders to verify medications administered were in accordance with the physician's instructions. -There were no orders to follow, so she administered medications according to the instructions on the pharmacy printed label. -The Administrator did not give instructions what to do when administering Resident #4's medications. -She did not have MARS to document the administration of medications to Resident #4. -She knew the staff person at the home where Resident #4 lived had the MARs with her at home #9, so she called that staff person and verbally told that she administered Resident #4's medications daily. -She administered Resident #4's medications three times daily, but called the staff person once daily. <p>Interview on 02/05/15 at 2:25 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -She brought Resident #4 to the facility on Monday, February 2, 2015. 	C 341		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 341	<p>Continued From page 9</p> <ul style="list-style-type: none"> -There was no staff available at the home where Resident #4 lived, so she brought the resident to this facility. -She was in a rush and did not bring Resident #4's record or MARs. -Resident #4's record and MARs were taken to another family care home (not where Resident #4 lived). -She did not give instructions for staff at that home to document the administration of Resident #4's medications. -It was the facility's policy that medications administered were to be documented immediately after the administration of the medication by the staff administering the medication. -She does not know why the SIC at this facility called another home for staff to document medication that staff did not administer or observed administered. -She also did not give any specific instructions to staff regarding documenting the administration of Resident #4's medications, "I was in a hurry and forgot." 	C 341		
C 415	<p>10A NCAC 13G .1201 (a) Resident Records</p> <p>10A NCAC 13G .1201 Resident Records</p> <p>(a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Facility Services and county departments of social services:</p> <ul style="list-style-type: none"> (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule 	C 415		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 415	<p>Continued From page 10</p> <p>.0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review the Adult Care Home failed to assure 1 of 4 sampled residents (Resident #4) had completed tuberculin test (TB) as required by the Commission for Health Services.</p> <p>The findings are:</p>	C 415		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 415	<p>Continued From page 11</p> <p>Observation on 02/04/15 at 11:40 am revealed: -Six residents were present at the facility. -Three residents were sitting in the common living room. -Two residents were in their bedroom. -One resident was in the bathroom.</p> <p>Interview on 02/04/15 at 11:50 am with the Supervisor-in-Charge (SIC) revealed: -Only 5 residents lived at the facility. -The resident identified as Resident #4 did not live at the facility. -The resident was visiting another resident at the facility. -Resident #4 was dropped off every morning. -She stayed at the facility for a couple of hours, and was picked up by someone.</p> <p>Confidential interviews with four residents revealed: -There was an emergency and Resident #4 had to come to the facility. -Resident #4 live at the facility since Monday, February 2, 2015. -Resident #4 ate breakfast, lunch and dinner with other residents at the facility. -Resident #4 slept in bedroom #3. -Facility staff gave Resident #4 medications daily.</p> <p>A request by the surveyor for Resident #4's record revealed: -There was no record at the facility. -There was no FL2 with orders. -No documentation of the resident's diagnoses, disorientation status, ambulation, TB testing, diet order, health care status, medication review, LHPS review, assessment and care plan or mental health.</p> <p>Interview on 02/04/15 at 12:10 pm with Resident</p>	C 415		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 415	<p>Continued From page 12</p> <p>#4 revealed:</p> <ul style="list-style-type: none"> -She lived at another family care home owned by the Administrator. -On Monday, February 2, 2015, there was an emergency at one of the homes and no staff was available, so she had to move this facility. -She was not given the option of staying at her home because the staff was sent to work at another home (#9). -She was not asked if she wanted to move, but informed that she would be at this home until Friday, February 6, 2015. -She slept in room #3. -She ate breakfast, lunch, and dinner at the facility. -Staff at this home administered her medications three times daily. -The Administrator informed her that she was supposed to return to her home on Friday, February 6, 2015. -She recalled having a TB test when she moved into her home. -She did not know where her records were kept. <p>Second interview on 02/04/15 at 12:40 pm with the SIC revealed:</p> <ul style="list-style-type: none"> -She did not tell the truth in her first interview for fear of getting in trouble. -Resident #4 lived at the facility since Monday, February 2, 2015. -There was an emergency with staff at another facility, and there was no one to watch Resident #4, so the resident was brought to the facility to live. -Resident #4 ate all meals at the facility. -There was no record or documentation brought with Resident #4 to the facility. -She was unaware if Resident #4 had a TB test, because the resident's record was not brought with her to the facility. 	C 415		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 415	Continued From page 13 Interview on 02/05/15 at 2:25 pm with the Administrator revealed: -She brought Resident #4 to the facility on Monday, February 2, 2015. -She did not bring Resident #4's record with medication orders with the resident to this home. -Resident #4's record was taken to another family care home (not where Resident #4 lived). -The resident had a first and second step TB test prior to being admitted to the home where the resident lived. -The TB results were in the resident's record. -It was the facility's policy that resident records follow the resident and be available on site where the resident resided. -She was in a rush and did not think to bring Resident #4's record.	C 415		
C 416	10A NCAC 13G .1201 (2) Resident Records 10A NCAC 13G .1201 Resident Records (2) Resident Register; This Rule is not met as evidenced by: Based on record review and interview, the facility failed to complete an initial assessment using the Resident Register within 72 hours of admission for 1 of 4 residents (Resident #4). The findings are: Observation on 02/04/15 at 11:40 am revealed: -Six residents were present at the facility. -Three residents were sitting in the common living room.	C 416		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 416	<p>Continued From page 14</p> <ul style="list-style-type: none"> -Two residents were in their bedroom. -One resident was in the bathroom. <p>Interview on 02/04/15 at 11:50 am with the Supervisor-in-Charge (SIC) revealed:</p> <ul style="list-style-type: none"> -Only 5 residents lived at the facility. -The resident identified as Resident #4 did not live at the facility. -The resident was visiting another resident at the facility. -Resident #4 was dropped off every morning. -She stayed at the facility for a couple of hours, and was picked up by someone. <p>Confidential interviews with four residents revealed:</p> <ul style="list-style-type: none"> -There was an emergency and Resident #4 had to come to the facility. -Resident #4 live at the facility since Monday, February 2, 2015. -Resident #4 ate breakfast, lunch and dinner with other residents at the facility. -Resident #4 slept in bedroom #3. -Facility staff gave Resident #4 medications daily. <p>A request by the surveyor for Resident #4's record revealed:</p> <ul style="list-style-type: none"> -There was no record at the facility. -There was no FL2 with orders. -No documentation of the resident's diagnoses, disorientation status, ambulation, TB testing, diet order, health care status, medication orders and drug review, LHPS review, assessment and care plan or mental health. <p>Interview on 02/04/15 at 12:10 pm with Resident #4 revealed:</p> <ul style="list-style-type: none"> -She lived at another family care home owned by the Administrator. -On Monday, February 2, 2015, there was an 	C 416		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 416	<p>Continued From page 15</p> <p>emergency at one of the homes and no staff was available, so she had to move this facility.</p> <p>-She was not given the option of staying at her home because the staff was sent to work at another home (#9).</p> <p>-She was not asked if she wanted to move, but informed that she would be at this home until Friday, February 6, 2015.</p> <p>-She slept in room #3.</p> <p>-She ate breakfast, lunch, and dinner at the facility.</p> <p>-Staff at this home administered her medications three times daily.</p> <p>-The Administrator informed her that she was supposed to return to her home on Friday, February 6, 2015.</p> <p>-She had a record that was at the home where she lived.</p> <p>-She did not know where her records were kept.</p> <p>-She was unaware of documents kept in her record.</p> <p>Second interview on 02/04/15 at 12:40 pm with the SIC revealed:</p> <p>-She did not tell the truth in her first interview for fear of getting in trouble.</p> <p>-Resident #4 lived at the facility since Monday, February 2, 2015.</p> <p>-There was an emergency with staff at another facility, and there was no one to watch Resident #4, so the resident was brought to the facility to live.</p> <p>-Resident #4 ate all meals at the facility.</p> <p>-There was no record or documentation brought with Resident #4 to the facility.</p> <p>-She was unaware of documents in Resident #4's record.</p> <p>-No record of documents were brought with the resident to this home.</p>	C 416		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 416	Continued From page 16 Interview on 02/05/15 at 2:25 pm with the Administrator revealed: -She brought Resident #4 to the facility on Monday, February 2, 2015. -There was a Resident Register prepared within 72 hours of Resident #4's admission to her home, but the record was not at this home. -She did not bring Resident #4's record with medication orders to this home with the resident. -Resident #4's record was taken to another family care home (not where Resident #4 lived). -It was the facility's policy that resident records follow the resident and be available on site where the resident resided. -She was in a rush and did not think to bring Resident #4's record.	C 416		
C 417	10A NCAC 13G .1201 (3) Resident Records 10A NCAC 13G .1201 Resident Records (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) home's grievance procedures; and (E) civil rights statement; This Rule is not met as evidenced by: Based on record review and interview, the facility	C 417		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 417	<p>Continued From page 17</p> <p>failed to complete a contract for services, accommodations and rates; house rules; Declaration of Residents' Rights; home's grievance procedures; and civil rights statement for 1 of 4 residents (Resident #4).</p> <p>The findings are:</p> <p>Observation on 02/04/15 at 11:40 am revealed: -Six residents were present at the facility. -Three residents were sitting in the common living room. -Two residents were in their bedroom. -One resident was in the bathroom.</p> <p>Interview on 02/04/15 at 11:50 am with the Supervisor-in-Charge (SIC) revealed: -Only 5 residents lived at the facility. -The resident identified as Resident #4 did not live at the facility. -The resident was visiting another resident at the facility. -Resident #4 was dropped off every morning. -She stayed at the facility for a couple of hours, and was picked up by someone.</p> <p>Confidential interviews with four residents revealed: -There was an emergency and Resident #4 had to come to the facility. -Resident #4 live at the facility since Monday, February 2, 2015. -Resident #4 ate breakfast, lunch and dinner with other residents at the facility. -Resident #4 slept in bedroom #3. -Facility staff gave Resident #4 medications daily.</p> <p>A request by the surveyor for Resident #4's record revealed: -There was no record at the facility.</p>	C 417		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 417	<p>Continued From page 18</p> <ul style="list-style-type: none"> -There was no FL2 with orders. -No documentation of the resident's diagnoses, disorientation status, ambulation, TB testing, diet order, health care status, medication orders and drug review, LHPS review, assessment and care plan or mental health. <p>Interview on 02/04/15 at 12:10 pm with Resident #4 revealed:</p> <ul style="list-style-type: none"> -She lived at another family care home owned by the Administrator. -On Monday, February 2, 2015, there was an emergency at another family care home and no staff was available, so she had to move this facility. -She was not given an option of staying at her family care home, but told it was an emergency and there was no staff to stay with her at the family care home where she lived. -She slept in room #3. -She ate breakfast, lunch, and dinner at the facility. -Staff administered her medications three times daily. -The Administrator told her that she was leaving this facility on Friday, February 6, 2015, and returning to the family care home where she lived. -She was unaware where her record with documents were located or of the documents in her record. <p>Second interview on 02/04/15 at 12:40 pm with the SIC revealed:</p> <ul style="list-style-type: none"> -She did not tell the truth in her first interview for fear of getting in trouble. -Resident #4 lived at the facility since Monday, February 2, 2015. -There was an emergency with staff at another facility, and there was no one to watch Resident 	C 417		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 417	<p>Continued From page 19</p> <p>#4, so the resident was brought to the facility to live.</p> <ul style="list-style-type: none"> -Resident #4 ate all meals at the facility. -There was no record or documentation brought with Resident #4 to the facility. -She administered Resident #4 medications three times daily, according to the instructions on the pharmacy printed label. -She was unaware of any documents related to Resident #4's admission to the family care home where the resident lived. -Resident #4 was not considered a new admission to this home, but a visitor and did not require any documents. -The SIC said it was the facility's policy that residents residing in the facility had a record on site with the resident. <p>Interview on 02/05/15 at 2:25 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -On Monday, February 2, 2015 there was an emergency, where a staff at another facility got sick. -She took the staff and two residents at the home where Resident #4 lived and sent them to the family care home (#9), where the staff got sick. -The reason she moved Resident #4 and other residents out of their home was that home had no open beds to move in residents from home #9. -It was easier to move the staff person and four residents (Resident #4) to another home temporarily. -Residents were moved as follows: -One resident to family care home #7, Resident #4 to this home, and two residents went to home #9 where she needed the staff person. -She did not have time to search for another staff because she was leaving town on Wednesday, February 4, for a funeral. -She did not ask residents if they wanted to 	C 417		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 417	Continued From page 20 move, "I was rushed and confused", thinking of ways to serve residents at all four homes. -The thought never occurred to send Resident #4's MARs and record with the resident to this home. -She did not think to bring Resident #4's record with the resident to this facility.	C 417		
C 418	10A NCAC 13G .1201 (4) Resident Records 10A NCAC 13G .1201Resident Records (4) resident assessment and care plan; This Rule is not met as evidenced by: Based on observation and interview, the facility failed to assure documentation of an assessment and care plan for 1 of 4 residents (Resident #4) living at the facility. The findings are: Observation on 02/04/15 at 11:40 am revealed: -Six residents were present at the facility. -Three residents were sitting in the common living room. -Two residents were in their bedroom. -One resident was in the bathroom. Interview on 02/04/15 at 11:50 am with the Supervisor-in-charge (SIC) revealed: -Only 5 residents lived at the facility. -The resident identified as Resident #4 did not live at the facility. -The resident was visiting another resident at the facility. -Resident #4 was dropped off every morning.	C 418		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 418	<p>Continued From page 21</p> <p>-She stayed at the facility for a couple of hours, and was picked up by someone.</p> <p>Confidential interviews with four residents revealed:</p> <p>-There was an emergency and Resident #4 had to come to the facility.</p> <p>-Resident #4 live at the facility since Monday, February 2, 2015.</p> <p>-Resident #4 ate breakfast, lunch and dinner with other residents at the facility.</p> <p>-Resident #4 slept in bedroom #3.</p> <p>-Facility staff gave Resident #4 medications daily.</p> <p>A request by the surveyor for Resident #4's record revealed:</p> <p>-There was no record at the facility.</p> <p>-There was no FL2 with orders.</p> <p>-No documentation of the resident's diagnoses, disorientation status, ambulation, TB testing, diet order, health care status, medication orders and drug review, LHPS review, assessment and care plan or mental health.</p> <p>Interview on 02/04/15 at 12:10 pm with Resident #4 revealed:</p> <p>-She lived at another family care home owned by the Administrator.</p> <p>-On Monday, February 2, 2015, there was an emergency at another family care home and no staff was available, so she had to move this facility.</p> <p>-She was not given an option of staying at her family care home, but told it was an emergency and there was no staff to stay with her at the family care home where she lived.</p> <p>-She slept in room #3.</p> <p>-She ate breakfast, lunch, and dinner at the facility.</p> <p>-Staff administered her medications three times</p>	C 418		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 418	<p>Continued From page 22</p> <p>daily.</p> <p>-The Administrator told her that she was leaving this facility on Friday, February 6, 2015, and returning to the family care home where she lived.</p> <p>-She was unaware where her record with documents were located or of the documents in her record.</p> <p>Second interview on 02/04/15 at 12:40 pm with the SIC revealed:</p> <p>-She did not tell the truth in her first interview for fear of getting in trouble.</p> <p>-Resident #4 lived at the facility since Monday, February 2, 2015.</p> <p>-There was an emergency with staff at another facility, and there was no one to watch Resident #4, so the resident was brought to the facility to live.</p> <p>-Resident #4 ate all meals at the facility.</p> <p>-There was no record or documentation brought with Resident #4 to the facility.</p> <p>-She administered Resident #4 medications three times daily, according to the instructions on the pharmacy printed label.</p> <p>-She was unaware of any documents related to Resident #4's admission to the family care home where the resident lived.</p> <p>-Resident #4 was not considered a new admission to this home, but a visitor and did not require any documents.</p> <p>-The SIC said it was the facility's policy that residents residing in the facility had a record on site with the resident.</p> <p>Interview on 02/05/15 at 2:25 pm with the Administrator revealed:</p> <p>-On Monday, February 2, 2015 there was an emergency, where a staff at another facility got sick.</p>	C 418		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 418	<p>Continued From page 23</p> <ul style="list-style-type: none"> -She took the staff and two residents at the home where Resident #4 lived and sent them to the family care home (#9), where the staff got sick. -The reason she moved Resident #4 and other residents out of their home was that home had no open beds to move in residents from home #9. -It was easier to move the staff person and four residents (Resident #4) to another home temporarily. -Residents were moved as follows: -One resident to family care home #7, Resident #4 to this home, and two residents went to home #9 where she needed the staff person. -She did not have time to search for another staff because she was leaving town on Wednesday, February 4, for a funeral. -She did not ask residents if they wanted to move, "I was rushed and confused", thinking of ways to serve residents at all four homes. -The thought never occurred to send Resident #4's MARs and record with the resident to this home. -Resident #4 had an assessment and care plan in her record. -She did not think to bring Resident #4's record with the resident to this facility. 	C 418		
C 419	<p>10A NCAC 13G .1201 (5) Resident Records</p> <p>10A NCAC 13G .1201Resident Records</p> <p>(5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter;</p> <p>This Rule is not met as evidenced by:</p>	C 419		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 419	<p>Continued From page 24</p> <p>Based on observation and interview, the facility failed to assure documentation of contacts with the resident's physician, physician service or other licensed health professional were available for review for 1 of 4 residents (Resident #4) living at the facility.</p> <p>The findings are:</p> <p>Observation on 02/04/15 at 11:40 am revealed: -Six residents were present at the facility. -Three residents were sitting in the common living room. -Two residents were in their bedroom. -One resident was in the bathroom.</p> <p>Interview on 02/04/15 at 11:50 am with the Supervisor-in-charge (SIC) revealed: -Only 5 residents lived at the facility. -The resident identified as Resident #4 did not live at the facility. -The resident was visiting another resident at the facility. -Resident #4 was dropped off every morning. -She stayed at the facility for a couple of hours, and was picked up by someone.</p> <p>Confidential interviews with four residents revealed: -There was an emergency and Resident #4 had to come to the facility. -Resident #4 live at the facility since Monday, February 2, 2015. -Resident #4 ate breakfast, lunch and dinner with other residents at the facility. -Resident #4 slept in bedroom #3. -Facility staff gave Resident #4 medications daily.</p> <p>A request by the surveyor for Resident #4's record revealed:</p>	C 419		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 419	<p>Continued From page 25</p> <ul style="list-style-type: none"> -There was no record at the facility. -There was no FL2 with orders. -No documentation of the resident's diagnoses, disorientation status, ambulation, TB testing, diet order, health care status, medication orders and drug review, LHPS review, assessment and care plan or mental health. <p>Interview on 02/04/15 at 12:10 pm with Resident #4 revealed:</p> <ul style="list-style-type: none"> -She lived at another family care home owned by the Administrator. -On Monday, February 2, 2015, there was an emergency at another family care home and no staff was available, so she had to move this facility. -She was not given an option of staying at her family care home, but told it was an emergency and there was no staff to stay with her at the family care home where she lived. -She slept in room #3. -She ate breakfast, lunch, and dinner at the facility. -Staff administered her medications three times daily. -The Administrator told her that she was leaving this facility on Friday, February 6, 2015, and returning to the family care home where she lived. -She was unaware where her record with documents were located. -She was also unaware of the documents in her record. <p>Second interview on 02/04/15 at 12:40 pm with the SIC revealed:</p> <ul style="list-style-type: none"> -She did not tell the truth in her first interview for fear of getting in trouble. -Resident #4 lived at the facility since Monday, February 2, 2015. 	C 419		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 419	<p>Continued From page 26</p> <ul style="list-style-type: none"> -There was an emergency with staff at another facility, and there was no one to watch Resident #4, so the resident was brought to the facility to live. -Resident #4 ate all meals at the facility. -There was no record or documentation brought with Resident #4 to the facility. -She administered Resident #4 medications three times daily, according to the instructions on the pharmacy printed label. -She was unaware of any documents related to Resident #4's admission to the family care home where the resident lived. -Resident #4 was not considered a new admission to this home, but a visitor and did not require any documents. -It was the facility's policy that residents residing in the facility had a record on site with the resident. -There was no record for Resident #4 because the resident was visiting, not living at the facility. <p>Interview on 02/05/15 at 2:25 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -On Monday, February 2, 2015 there was an emergency, where a staff at another facility got sick. -She took the staff and two residents at the home where Resident #4 lived and sent them to the family care home (#9), where the staff got sick. -The reason she moved Resident #4 and other residents out of their home was that home had no open beds to move in residents from home #9. -It was easier to move the staff person and four residents (Resident #4) to another home temporarily. -Residents were moved as follows: -One resident to family care home #7, Resident #4 to this home, and two residents went to home #9 where she needed the staff person. 	C 419		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 419	<p>Continued From page 27</p> <ul style="list-style-type: none"> -She did not have time to search for another staff because she was leaving town on Wednesday, February 4, for a funeral. -She did not ask residents if they wanted to move, "I was rushed and confused", thinking of ways to serve residents at all four homes. -Resident #4 had a record with physician orders and communication with other health care professionals. -Resident #4's record was not at this home, but the record was sent to another family care home. -The thought never occurred to her to send Resident #4's MARs and record with the resident to this home. -Although it was the facility's policy that residents record be onsite at the home where the resident resided, she did not think to bring Resident #4's record with the resident to this facility. 	C 419		
C 420	<p>10A NCAC 13G .1201 (6) Resident Records</p> <p>10A NCAC 13G .1201Resident Records</p> <p>(6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation;</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to assure orders or written treatments or procedures from a physician or other licensed health professional and their implementation for 1 of 4 residents (Resident #4).</p> <p>The findings are:</p> <p>A request by the surveyor for Resident #4's</p>	C 420		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 420	<p>Continued From page 28</p> <p>record revealed:</p> <ul style="list-style-type: none"> -There was no record at the facility. -There was no FL2 with orders. -No documentation of the resident's diagnoses, disorientation status, ambulation, TB testing, diet order, health care status, medication orders or drug review, LHPS review, assessment and care plan or mental health. <p>Observation on 02/04/15 at 1:40 pm of Resident #4's medications on hand at the facility revealed:</p> <ul style="list-style-type: none"> -Four containers of bubble packed medications. -Each container had Resident #4's name, dispensing date, name of the medications, strength, and dosage. -One bubble pack had Cogentin 1mg twice daily, Ferrous Sulfate 325mg three times daily. -A second bubble pack had Ferrous Sulfate 325mg three times daily, and Lamotrigine 100mg once daily. -A third bubble pack had Abilify 20mg once daily. -A fourth bubble pack has Ferrous Sulfate 325mg three times daily. <p>Interview on 02/04/15 at 12:10 pm with Resident #4 revealed:</p> <ul style="list-style-type: none"> -She lived at another family care home owned by the Administrator. -On Monday, February 2, 2015, there was an emergency at another family care home and no staff was available, so she had to move this facility. -She was not given an option of staying at her family care home, but told it was an emergency and there was no staff to stay with her at the family care home where she lived. -The Administrator told her that she was leaving this facility on Friday, February 6, 2015, and returning to the family care home where she lived. 	C 420		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 420	<p>Continued From page 29</p> <ul style="list-style-type: none"> -She slept in room #3. -She ate breakfast, lunch, and dinner at the facility. -Staff administered her medications three times daily. -She was unaware of medications ordered, she took what they gave her. -She was unaware where her record with documents were located. -She was also unaware of the documents in her record. <p>Second interview on 02/04/15 at 12:40 pm with the SIC revealed:</p> <ul style="list-style-type: none"> -She did not tell the truth in her first interview for fear of getting in trouble. -Resident #4 lived at the facility since Monday, February 2, 2015. -There was an emergency with staff at another facility, and there was no one to watch Resident #4, so the resident was brought to the facility to live. -Resident #4 ate all meals at the facility. -There was no record or documentation brought with Resident #4 to the facility. -The administrator brought with Resident #4 four bubble packages of medications. -She administered Resident #4 medications three times daily, at 8:00 am, 2:00 pm and 8:00 pm. -The medication were administered according to the instructions on the pharmacy printed label. -She was not sure if the medications administered were according to the current physician orders. -She did not have any current orders to follow to ensure she administered medications correctly. -She had not contacted the pharmacy or the resident's physician to clarify the order. -It was the facility's policy that residents residing in the facility had a record on site with the 	C 420		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 420	<p>Continued From page 30</p> <p>resident.</p> <p>-There was no record for Resident #4 because the resident was visiting, not living at the facility.</p> <p>Interview on 02/05/15 at 2:25 pm with the Administrator revealed:</p> <p>-On Monday, February 2, 2015 there was an emergency, where a staff at another facility got sick.</p> <p>-She took the staff and two residents at the home where Resident #4 lived and sent them to the family care home (#9), where the staff got sick.</p> <p>-The reason she moved Resident #4 and other residents out of their home was that home had no open beds to move in residents from home #9.</p> <p>-It was easier to move the staff person and four residents (Resident #4) to another home temporarily.</p> <p>-Residents were moved as follows:</p> <p>-One resident to family care home #7, Resident #4 to this home, and two residents went to home #9 where she needed the staff person.</p> <p>-She did not have time to search for another staff because she was leaving town on Wednesday, February 4, for a funeral.</p> <p>-She did not ask residents if they wanted to move, "I was rushed and confused", thinking of ways to serve residents at all four homes.</p> <p>-Resident #4 had a record with physician orders and communication with other health care professionals.</p> <p>-Resident #4's record was not at this home, but the record was sent to another family care home.</p> <p>-The thought never occurred to her to send Resident #4's MARs and record with the resident to this home.</p> <p>-Although it was the facility's policy that residents record be onsite at the home where the resident resided, she did not think to bring Resident #4's record with the resident to this facility.</p>	C 420		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 421	<p>10A NCAC 13G .1201 (7) Resident Records</p> <p>10A NCAC 13G .1201Resident Records</p> <p>(7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review the Adult Care Home failed to assure documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 for 1 of 4 sampled residents (Resident #4).</p> <p>The findings are:</p> <p>Observation on 02/04/15 at 11:40 am revealed: -Six residents were present at the facility. -Three residents were sitting in the common living room. -Two residents were in their bedroom. -One resident was in the bathroom.</p> <p>Interview on 02/04/15 at 11:50 am with the Supervisor-in-Charge (SIC) revealed: -Only 5 residents lived at the facility. -The resident identified as Resident #4 did not live at the facility. -The resident was visiting another resident at the facility. -Resident #4 was dropped off every morning. -She stayed at the facility for a couple of hours, and was picked up by someone.</p>	C 421		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 421	<p>Continued From page 32</p> <p>Confidential interviews with four residents revealed:</p> <ul style="list-style-type: none"> -There was an emergency and Resident #4 had to come to the facility. -Resident #4 live at the facility since Monday, February 2, 2015. -Resident #4 ate breakfast, lunch and dinner with other residents at the facility. -Resident #4 slept in bedroom #3. -Facility staff gave Resident #4 medications daily. <p>A request by the surveyor for Resident #4's record revealed:</p> <ul style="list-style-type: none"> -There was no record at the facility. -There was no FL2 with orders. -No documentation of the resident's diagnoses, disorientation status, ambulation, TB testing, diet order, health care status, medication review, LHPS review, assessment and care plan or mental health. <p>Interview on 02/04/15 at 12:10 pm with Resident #4 revealed:</p> <ul style="list-style-type: none"> -She lived at another family care home owned by the Administrator. -On Monday, February 2, 2015, there was an emergency at another family care home and no staff was available, so she had to move this facility. -She was not given an option of staying at her family care home, but told it was an emergency and there was no staff to stay with her at the family care home where she lived. -The Administrator told her that she was leaving this facility on Friday, February 6, 2015, and returning to the family care home where she lived. -She slept in room #3. -She ate breakfast, lunch, and dinner at the facility. 	C 421		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 421	<p>Continued From page 33</p> <ul style="list-style-type: none"> -Staff administered her medications three times daily. -She was unaware of medications ordered, she took what they gave her. -She was unaware where her record with documents were located. -She was also unaware of the documents in her record. -She does recall receiving the flu shot and TB test, but was unaware where the documents were located. -She thought maybe the documents were in her record at the facility where she lived. <p>Second interview on 02/04/15 at 12:40 pm with the SIC revealed:</p> <ul style="list-style-type: none"> -She did not tell the truth in her first interview for fear of getting in trouble. -Resident #4 lived at the facility since Monday, February 2, 2015. -There was an emergency with staff at another facility, and there was no one to watch Resident #4, so the resident was brought to the facility to live. -Resident #4 ate all meals at the facility. -There was no record or documentation brought with Resident #4 to the facility. -She was unaware if there was documentation of immunizations against influenza virus and pneumococcal disease in Resident #4's record. -She was also unaware if the resident had been vaccinated against the diseases. -She was aware that Resident #4 had a record, but it was not at this facility. -The administrator brought with Resident #4 four bubble packages of medications. -No record was brought with the resident to this facility. <p>Interview on 02/05/15 at 2:25 pm with the</p>	C 421		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 421	<p>Continued From page 34</p> <p>Administrator revealed:</p> <ul style="list-style-type: none"> -On Monday, February 2, 2015 there was an emergency, where a staff at another facility got sick. -She took the staff and two residents at the home where Resident #4 lived and sent them to the family care home (#9), where the staff got sick. -The reason she moved Resident #4 and other residents out of their home was that home had no open beds to move in residents from home #9. -It was easier to move the staff person and four residents (Resident #4) to another home temporarily. -Residents were moved as follows: -One resident to family care home #7, Resident #4 to this home, and two residents went to home #9 where she needed the staff person. -She did not have time to search for another staff because she was leaving town on Wednesday, February 4, for a funeral. -She did not ask residents if they wanted to move, "I was rushed and confused", thinking of ways to serve residents at all four homes. -She did not bring a record or documentation with Resident #4 to the home. -Resident #4 had documentation of immunizations in her record, but it was not at this facility. -Resident #4's record was sent to another family care home. -The thought never occurred to her to bring Resident #4's record with the resident to this home. -Although it was the facility's policy that residents record be onsite at the home where the resident resided, she did not think to bring Resident #4's record with the resident to this facility. 	C 421		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 424	Continued From page 35	C 424		
C 424	<p>10A NCAC 13G .1202 Transfer Of Resident's Records</p> <p>10A NCAC 13G .1202 Transfer Of Resident's Records</p> <p>At the request of the resident or his responsible person, copies of all pertinent information shall be given to the administrator of the licensed home to which the resident moves. The FL-2 or MR-2 shall be provided unless:</p> <p>(1) It was completed more than 90 days before the move; or</p> <p>(2) There has been an apparent change in the mental or physical condition of the resident.</p> <p>This Rule is not met as evidenced by: Based on observation, interview, and record review the the facility failed to assure copies of all pertinent information was provided to staff of the licensed home to which the resident was moved including FL2 for 1 of 4 sampled residents (Resident #4).</p> <p>The findings are:</p> <p>Observation on 02/04/15 at 11:40 am revealed: -Six residents were present at the facility. -Three residents were sitting in the common living room. -Two residents were in their bedroom. -One resident was in the bathroom.</p> <p>Interview on 02/04/15 at 11:50 am with the Supervisor-in-Charge (SIC) revealed: -Only 5 residents lived at the facility. -The resident identified as Resident #4 did not live at the facility.</p>	C 424		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 424	<p>Continued From page 36</p> <ul style="list-style-type: none"> -The resident was visiting another resident at the facility. -Resident #4 was dropped off every morning. -She stayed at the facility for a couple of hours, and was picked up by someone. <p>Confidential interviews with four residents revealed:</p> <ul style="list-style-type: none"> -There was an emergency and Resident #4 had to come to the facility. -Resident #4 live at the facility since Monday, February 2, 2015. -Resident #4 ate breakfast, lunch and dinner with other residents at the facility. -Resident #4 slept in bedroom #3. -Facility staff gave Resident #4 medications daily. <p>A request by the surveyor for Resident #4's record revealed:</p> <ul style="list-style-type: none"> -There was no record at the facility. -There was no FL2 with orders. -No documentation of the resident's diagnoses, disorientation status, ambulation, TB testing, diet order, health care status, medication review, LHPS review, assessment and care plan or mental health. <p>Interview on 02/04/15 at 12:10 pm with Resident #4 revealed:</p> <ul style="list-style-type: none"> -She lived at another family care home owned by the Administrator. -On Monday, February 2, 2015, there was an emergency at another family care home and no staff was available, so she had to move this facility. -She was not given an option of staying at her family care home, but told it was an emergency and there was no staff to stay with her at the family care home where she lived. -The Administrator told her that she was leaving 	C 424		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 424	<p>Continued From page 37</p> <p>this facility on Friday, February 6, 2015, and returning to the family care home where she lived.</p> <ul style="list-style-type: none"> -She slept in room #3. -She ate breakfast, lunch, and dinner at the facility. -Staff administered her medications three times daily. -She was unaware where her record with documents were located. -She was also unaware of the documents in her record. -She thought maybe the documents were in her record at the facility where she lived. <p>Second interview on 02/04/15 at 12:40 pm with the SIC revealed:</p> <ul style="list-style-type: none"> -She did not tell the truth in her first interview for fear of getting in trouble. -Resident #4 lived at the facility since Monday, February 2, 2015. -There was an emergency with staff at another facility, and there was no one to watch Resident #4, so the resident was brought to the facility to live. -Resident #4 ate all meals at the facility. -There was no record or documentation brought with Resident #4 to the facility. -She was aware that Resident #4 had a record, but it was not at this facility. <p>Interview on 02/05/15 at 2:25 pm with the Administrator revealed:</p> <ul style="list-style-type: none"> -On Monday, February 2, 2015 there was an emergency, where a staff at another facility got sick. -She took the staff and two residents at the home where Resident #4 lived and sent them to the family care home (#9), where the staff got sick. -The reason she moved Resident #4 and other 	C 424		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320
---	---

(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
C 424	<p>Continued From page 38</p> <p>residents out of their home was that home had no open beds to move in residents from home #9.</p> <p>-It was easier to move the staff person and four residents (Resident #4) to another home temporarily.</p> <p>-Residents were moved as follows:</p> <p>-One resident to family care home #7, Resident #4 to this home, and two residents went to home #9 where she needed the staff person.</p> <p>-She did not have time to search for another staff because she was leaving town on Wednesday, February 4, for a funeral.</p> <p>-She did not ask residents if they wanted to move, "I was rushed and confused", thinking of ways to serve residents at all four homes.</p> <p>-She did not bring a record or documentation with Resident #4 to the home.</p> <p>-Resident #4's record was sent to another family care home.</p> <p>-The thought never occurred to her to bring Resident #4's record with the resident to this home.</p> <p>-Although it was the facility's policy that residents record be onsite at the home where the resident resided, she did not think to bring Resident #4's record with the resident to this facility.</p>	C 424		