Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL079031	A. BUILDING: ____ B. WING ____	10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEVERLY RUCKER'S FAMILY CARE HOME	**1123 CRUTCHFIELD ROAD 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 an Annual survey on 10/27/16.	C 000		
C 212	10A NCAC 13G .0703 (a) Resident Register 10A NCAC 13G .0703 Resident Register (a) A family care home's administrator or supervisor-in-charge and the resident or the resident's responsible person shall complete and sign the Resident Register within 72 hours of the resident's admission to the home. The Resident Register is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or at no charge from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. The facility may use a resident information form other than the Resident Register as long as it contains at least the same information as the Resident Register. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to complete a Resident Register upon admission in October 2016 for 1 of 3 sampled residents (Resident #3). The findings are: Review of Resident #3's current FL2 dated 10/13/16 revealed: -Diagnoses included diabetes mellitus; mixed hyperlipidemia, and hypertension. Observation on 10/27/16 at 11:10 am during the initial tour of the facility revealed: -The Supervisor-in-Charge/Medication Aide (SIC) was in the kitchen preparing the lunch meal.	C 212		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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C 212	Continued From page 1 -There were three plates with place settings on the kitchen table. -The SIC removed one place setting from the table. -There were three resident rooms, one observed near the kitchen, and two down the hall from the kitchen. -The SIC closed the bedroom door to bedroom #1, which was near the kitchen. -One resident was observed sitting in the living room common sitting area watching television. -A second resident was observed sitting in her bedroom. Interview on 10/27/16 at 11:16 am with the Medication Aide/Supervisor-In-Charge (MA) revealed: -There were only two residents living in the facility. -No other residents living in the facility, but the two observed. -There was no need for the surveyor to go into bedroom #1, or to her room so she closed the door to the two rooms. Observation on 10/27/16 at 11:48 am revealed: -The Administrator was observed in bedroom #1. -The Administrator was observed leading a person out of bedroom #1, and leading the person by the hand out the back door of the facility, which was near the kitchen. Interview on 10/27/16 at 12:05 pm with the Administrator revealed: -The person that she led out the back door of the facility had resided at the facility since Monday, October 17, 2016. -Resident #3 came from another family care home that was consolidating all their homes, and no longer had room for Resident #3.	C 212		

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C 212	Continued From page 2 -She did not consider that person to be a resident of the facility. -She had not initiated any admission papers but the resident was in "limbo" until she decided if the resident was a "good fit" for the facility. -She was aware according to regulations that she had to admit residents living at the facility, but she wanted to "try" the resident before admitting her to the facility. -If Resident #3 was not a "good fit" she would send the resident back to the family care home where she came from. -The resident ate all her meals at the facility, and slept at the facility. -Resident #3 was blind, and required staff assistance with transferring, ambulation, toileting, eating, dressing, and medication administration. -Resident #3's medications were administered at the facility. -Although Resident #3 had lived at the facility for more than 10 days, she did not consider her a resident. -She did not prepare MARs for Resident #3. Second interview on 10/27/16 at 2:33 pm with the Administrator revealed: -She had not created a record for Resident #3 because she was not sure she wanted to admit Resident #3 as a permanent resident. -She borrowed Resident #3's record from the discharging facility. -She was given the record temporally to determine if she wanted to keep the resident. -She had a current FL2, but it was at her office. -She had not prepared any admitting documents for Resident #3. Interview on 10/27/16 at 3:16 pm with Resident #3 revealed: -She was blind and unable to see.	C 212		

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C 212	Continued From page 3 -Facility staff helped her get in and out of bed, assisted with getting dressed, getting from her room to the dining room, living room and bathroom room, and showering. -She moved the recently, but was unable to determine exactly how long she lived at the facility. -Facility staff administered medications to her in the morning and in the evening. Review of Resident #3's current FL2 dated 10/13/16 revealed: -Diagnoses included diabetes mellitus; mixed hyperlipidemia, and hypertension.	C 212		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on interview, record review, and observation the facility failed to assure documentation of medication administration record was recorded immediately following the administration of medication for 1 of 3 sampled residents (#3).	C 341		

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C 341	Continued From page 4 The findings are: Review of Resident #3's current FL2 dated 10/13/16 revealed: -Diagnoses included diabetes mellitus; mixed hyperlipidemia, and hypertension. -Orders for medications included: Theragram M (multi-vitamin) once daily; Omeprazole (used to reduce stomach acid) 20mg once daily; Quinipril (used to treat hypertension) 40mg once daily; Simvastatin (used to lower bad cholesterol) 40mg once daily; Trazadone (used to treat depression) 100mg at bedtime; Amlodipine 10mg once daily; Aspirin EC (used as a blood thinner) 81mg once daily; Benztropine Mes (used to treat involuntary movement due to the side effect or psychiatric drugs) 0.5mg twice daily; Loxapine (used to treat dementia) 25mg twice daily; Melatonin (used to help with sleep) 5mg (2 tablets = 10mg) at bedtime; Metoprolol (used to treat hypertension) Succ ER 25mg once daily; Novolog 70/30 mix (used to lower blood sugar levels) 50 units subcutaneously twice daily before meals for blood sugars greater than 90. Observation on 10/27/16 at 2:06 pm of Resident #3's medications on hand at the facility revealed: -Centrum Silver once daily; Omeprazole 20mg once daily; Quinipril 40mg once daily; Simvastatin 40mg once daily; Trazadone 100mg at bedtime; Amlodipine 10mg once daily; Aspirin EC 81mg once daily; Benztropine Mes 0.5mg twice daily; Loxapine 25mg twice daily; Melatonin 5mg (2 tablets = 10mg) at bedtime; Metoprolol Succ ER 25mg once daily; Novolog 70/30 mix 50 units subcutaneously twice daily before meals for blood sugars greater than 90. Review of Resident #3's glucometer revealed: -Blood sugar readings.	C 341		

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C 341	Continued From page 5 -The glucometer was not set with the time and date. -There were readings with blood sugars ranging from 209 to 531. -Because there was no documented record of administration it could not be determined exactly when the blood sugars were obtained. Review of all resident records in the facility on 10/27/16 at 2:12 pm revealed Resident #3 did not have a record at the facility. Interview on 10/27/16 at 2:14 pm revealed with the Medication Aide revealed: -She administered medications to Resident #3 twice daily. -She also checked Resident #3's blood sugars twice daily. -She did not record the administration of the medications or the blood sugars obtained because she did not consider Resident #3 a resident at the facility. Interview on 10/27/16 at 2:33 pm with the Administrator revealed: -She had not created a record for Resident #3 because she not sure she wanted to admit Resident #3 as a permanent resident. -She "borrowed" Resident #3's record from the discharging facility. -She was given the record to determine if she wanted to keep the resident. -She had a current FL2, but it was at her office. Interview on 10/27/16 at 3:16 pm with Resident #3 revealed: -She was blind and unable to see. -Facility staff helped her get in and out of bed, assisted with getting dressed, getting from her room to the dining room, living room and	C 341		

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C 341	Continued From page 6 bathroom room, and showering. -She moved the recently, but was unable to determine exactly how long she lived at the facility. -Facility staff administered medications to her in the morning and in the evening. -Facility staff checked her blood sugar two times a day.	C 341		