

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL079031	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 05/07/2021
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NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1123 CRUTCHFIELD ROAD REIDSVILLE, NC 27320
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C 000	Initial Comments	C 000		
C 074	<p>10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings</p> <p>10A NCAC 13G .0315 Housekeeping And Furnishings</p> <p>(a) Each family care home shall:</p> <p>(1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure walls, ceilings and floors in the residents' bathroom and hallway were kept clean and in good repair.</p> <p>The findings are:</p> <p>Observation of the residents' bathroom on 05/07/21 at 9:18am revealed:</p> <ul style="list-style-type: none"> -There were yellow and brown stains on the linoleum flooring. -There was a black substance on the grout around the faucet and around the grout where the tub connects to the shower walls. -There was a brownish substance around the short grab bar mount and around the piece of wood that connected the grab bar to the front wall of the shower. -There was a black substance around the long grab bar mount and around the piece of wood 	C 074		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 074	<p>Continued From page 1</p> <p>that connected the grab bar to the side wall of the shower.</p> <ul style="list-style-type: none"> -The wood trim on the outside bottom of the tub had rotted in an area of 2-3 inches leaving a hole between the rest of the wood trim and tub. -There was a speckled black substance on the ceiling that extended 2 to 3 inches out from the molding and ran 8 to 10 feet alongside the molding. -There was a speckled back substance in patches on the ceiling at the back of the shower. -There was an area about 1 foot long on the floor in front of the tub that sunk in when stepped on. -The light fixture on the ceiling had about a ¼ of an inch layer of dust on it. <p>Interview with the Supervisor-in-Charge on 05/07/21 at 9:42am revealed:</p> <ul style="list-style-type: none"> -She cleaned the bathroom (including the tub/shower) every day. -She did not know what the black substance was in the tub/shower, but it would not come off when cleaned. -She had noticed the dust on the light fixture, but she had not had a chance to dust the fixture yet as she just started working again at the facility on 05/03/21. -She had noticed the black substance on the ceiling, but she had not reported it to the Administrator. <p>Observation of the residents' hallway on 05/07/21 at 9:33am revealed:</p> <ul style="list-style-type: none"> -There was an area of the floor that was very soft when stepped on outside of resident room #2 and was about 1 to 1 and 1/2 feet long and about 3 to 4 inches wide. -The linoleum floor covering was ripped and there was about a 3 inch piece of linoleum missing exposing the floor padding. 	C 074		

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C 074	<p>Continued From page 2</p> <p>-When the area was stepped on, it felt as if the floor would give away.</p> <p>Interview with the resident who resided in bedroom #2 on 05/07/21 at 6:26pm revealed:</p> <p>-Staff cleaned the bathrooms every day.</p> <p>-She had not noticed any black or brown substance in the tub area or on the ceilings in the bathroom.</p> <p>-There was a "man" who came out to the facility in November or December 2020 and looked at the floor in in the hallway in front of her room and in the bathroom area.</p> <p>-He told her to be careful and not to walk on the soft area in the hallway in front of her room because he did not want anything to happen to her.</p> <p>-She tried to walk around the area when she walked in the hallway.</p> <p>-She had not seen any repairs completed on the floor in the hallway or the bathroom area.</p> <p>Interview with the Administrator on 05/07/21 at 6:37pm revealed:</p> <p>-She knew about the sinking areas in the resident hallway and resident bathroom.</p> <p>-The floor areas in the resident hallway and bathroom had been sinking in since at least February 2021.</p> <p>-She had a "man" who had done work on a neighbor's home come out to the facility to fix the floor areas.</p> <p>-The "man" came out on a Sunday in February 2021 and looked at the floors and he was supposed to come back on the following Monday, but he never returned.</p> <p>-After she saw that he was not going to return, she contacted someone who had done work for her in the past and that person had not shown up either.</p>	C 074		

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C 074	Continued From page 3 -She had not made contact with any other person or company who could assess and resolve the issues with the sinking floors in the resident hallway and resident bathroom. -She was not aware of the brown and black substances in the tub/shower areas and the black substance on the ceiling of the resident bathroom.	C 074		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility was kept clean, orderly and free of hazards related to roaches in the kitchen area, the resident's bathroom, and a resident's room (resident room #1). The findings are: Observation of the hallway bathroom on 05/07/21 at 9:21am revealed: -A roach was crawling along the side of the tub. -Resident room #1 was directly across the hallway from the hallway bathroom. -There was a white powdery substance along the	C 078		

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C 078	<p>Continued From page 4</p> <p>perimeter of the bathroom.</p> <p>Observation of the hallway bathroom on 05/07/21 at 6:22pm revealed there was a roach crawling into the doorway of the bathroom from the hallway.</p> <p>Observation of the living room area on 05/07/21 at 9:33am revealed there were 3 dead roaches which had been stepped on.</p> <p>Observation of a resident room #1 on 05/07/21 at 9:26am revealed there was a white powdery substance along the perimeter of Resident #2's room.</p> <p>Observation of resident room #1's on 05/07/21 at 11:56am revealed there were 2 roaches crawling on the floor.</p> <p>Interview with a resident in room #1 on 05/07/21 at 9:27am revealed: -She saw roaches crawling down the wall and on the mirror in her room. -She went to bed at 8:00pm and woke up at 2:00am some nights because she felt roaches crawling on her. -When she woke up, she could not go back to sleep because she was afraid of the roaches and her room needed to be sprayed. -She did not know what the white powdery substance was along the perimeter of her room and bathroom, and she did not know who put it down.</p> <p>A second interview with the resident in room #1 on 05/07/21 at 6:19pm revealed: -She told the Administrator, the Supervisor-in-Charge (SIC) and her family member there were roaches in her room, and</p>	C 078		

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C 078	<p>Continued From page 5</p> <p>they were waking her up at night.</p> <ul style="list-style-type: none"> -The Administrator told her she was going to spray. -If the Administrator could not spray, she needed to pay someone else to spray. -The roaches had been in her room for over a year. -She did not like the roaches and they caused her to not be able to sleep at night. <p>Observation of the kitchen on 05/07/21 at 12:10pm revealed:</p> <ul style="list-style-type: none"> -There was a roach crawling on the kitchen counter where food had been prepared. -There were food items sitting on the counter. -There was a white powdery substance along the perimeter of the floor in the kitchen floor. <p>Interview with the Supervisor-in-Charge (SIC) on 05/0721 at 9:42am revealed:</p> <ul style="list-style-type: none"> -She had been staying overnight at the facility since 05/03/21. -She had only seen 1 roach in the kitchen area crawling on a door leading to the outside smoking area. -She had not seen any dead roaches. -She did not know what the white powdery substance was, but she asked the Administrator about it, and the Administrator told her it was a treatment for roaches. -The resident in room #1 complained about roaches in the facility earlier in the week and on today, 05/07/21. -She only knew the resident in room #1 to be unable to sleep one night since 05/03/21 and that was because the resident was having issues with her catheter. -She did not know about any nights prior to 05/03/21. 	C 078		

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C 078	<p>Continued From page 6</p> <p>Interview with a representative from the pest control company on 05/07/21 at 12:38pm revealed:</p> <ul style="list-style-type: none"> -Pest control services were provided quarterly at the facility. -The facility was serviced in May 2020, August 2020, November 2020, and February 2021. -The technicians treated the perimeter of the home and the inside of the home with each service visit. -The treatment was a spray for insects and pests including roaches. -She did not know what the white powdery substance was along the perimeter of the walls in resident room #1, the bathroom, and the kitchen. -The pest control technicians only used a spray for roaches and roach gel bait. -There was a roach gel bait placed in the facility twice in 2019, but there had not been a roach gel bait placed recently. -If the facility had issues with roaches between treatments, they could reach out to the pest control company to request a service visit. -There had not been any requests for additional treatment for roaches and no treatments had been provided by the pest control company since February 2021. -The next quarterly visit was scheduled for 05/12/21. <p>Interview with the Administrator on 05/07/21 at 4:48pm revealed:</p> <ul style="list-style-type: none"> -The resident in room #1 complained to her about the roaches and she contacted the pest control company, but she did not remember when. -The pest control company told her they would only spray the outside of the home, but it should stop roaches from entering. -She used an over the counter spray for roaches in resident room #1 and all over the facility. 	C 078		

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C 078	Continued From page 7 -She did not know what the white powdery substance was, but one of the staff probably put the substance down along the perimeter of the walls in the kitchen, the bathroom, and resident room #1. -The resident in room #1 ate in her room and she thought that was what was causing the roaches.	C 078		
C 174	10A NCAC 13G .0505(1)(2) Training On Care Of Diabetic Residents 10A NCAC 13G .0505 Training On Care Of Diabetic Residents A family care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; appropriate administration times; and (g) sliding scale insulin administration. This Rule is not met as evidenced by: TYPE B VIOLATION	C 174		

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C 174	<p>Continued From page 8</p> <p>Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled staff, (Staff A, B, and C), had completed training on the care of the diabetic resident prior to the administration of insulin.</p> <p>The findings are:</p> <ol style="list-style-type: none"> Review of Staff A's, Supervisor-in-Charge (SIC), personnel record revealed: <ul style="list-style-type: none"> -Staff A was hired on 04/24/20. -There was no documentation of completion of training on care of diabetic residents. <p>Review of a resident's Medication Administration Record (MAR) for March 2021 revealed Staff A documented Fingerstick Blood Sugars (FSBS) and administering insulin for 23 days between 03/01/21 and 03/31/21.</p> <p>Review of a resident's MAR for April 2021 revealed Staff A documented FSBS and administering insulin for 20 days between 04/01/21 through 04/26/21.</p> <p>Attempted interview with Staff A on 05/07/21 at 4:48pm was unsuccessful.</p> <p>Interview with the Administrator on 05/07/21 at 4:49pm revealed: <ul style="list-style-type: none"> -Staff A had diabetic care training in December 2020 prior to working at the facility. -She did not have contact information for Staff A. -Staff A called her when she was ready to work. </p> <p>Refer to interview with the Administrator on 05/07/21 at 4:49pm.</p> <ol style="list-style-type: none"> Review of Staff B's, Supervisor-in-Charge (SIC), personnel record revealed: 	C 174		

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C 174	<p>Continued From page 9</p> <ul style="list-style-type: none"> -There was no hire date. -Her job title was SIC. -There was no documentation of completion of training on care of diabetic residents. <p>Review of a resident's Medication Administration Record (MAR) for April 2021 revealed Staff B documented Fingerstick Blood Sugars (FSBS) and documented administering insulin for 5 days from 04/26/21 through 04/30/21.</p> <p>Review of a resident's MAR for May 2021 revealed Staff B documented fingerstick blood sugars (FSBS) and administration of insulin for 3 days from 05/01/21 through 05/03/21.</p> <p>Attempted interview with Staff B on 05/07/21 at 4:48pm was unsuccessful.</p> <p>Interview with the Administrator on 05/07/21 at 4:49pm revealed:</p> <ul style="list-style-type: none"> -Staff B did not have diabetic care training. -She did not have contact information for Staff B. -She did not know if Staff B would come back to work. <p>Refer to interview with the Administrator on 05/07/21 at 4:49pm.</p> <p>3. Review of Staff C's, Supervisor-in-Charge (SIC), personnel record revealed:</p> <ul style="list-style-type: none"> -There was no hire date. -Her job title was SIC. -There was no documentation of completion of training on care of diabetic residents. <p>Review of a resident's Medication Administration Record (MAR) for May 2021 revealed Staff C documented fingerstick blood sugars (FSBS) and administration of insulin for 5 days from 05/03/21</p>	C 174		

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C 174	<p>Continued From page 10 through 05/07/21.</p> <p>Interview with Staff C on 05/07/21 at 4:45pm revealed: -She was hired at the facility in 2019, but she also worked at other facilities under the same ownership. -She administered medications to the residents during her shift. -There was one resident who was prescribed insulin by injection. -She administered the insulin injections to the resident when she worked. -She thought she had diabetic care training in 2019.</p> <p>Interview with the Administrator on 05/07/21 at 4:49pm revealed she thought Staff C had diabetic care training, but she did not remember when.</p> <p>Refer to interview with the Administrator on 05/07/21 at 4:49pm.</p> <p>Interview with the Administrator on 05/07/21 at 4:49pm revealed: -She was responsible for assuring staff had completed diabetic training. -She kept diabetic care training certificates in a separate notebook.</p> <p>A request was made for a copy of staff certificates for training on care of diabetics but was not provided prior to exit on 05/07/21.</p> <p>The facility failed to ensure staff who administered insulin to residents had completed training on care of diabetic residents resulting in errors in the administration of insulin. This failure was detrimental to the health and welfare of the residents which constitutes a Type B Violation.</p>	C 174		

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C 174	Continued From page 11 The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/24/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 21, 2021.	C 174		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure 1 of 3 sampled residents (Resident #2) was treated with consideration and dignity related to having roaches in her room and being afraid of roaches. The findings are: Observation of Resident #2's room on 05/07/21 at 9:26am revealed there was a white powdery substance along the perimeter of Resident #2's room. Observation of Resident #2's room on 05/07/21 at 11:56am revealed there were 2 roaches were crawling on the floor. Interview with Resident #2 on 05/07/21 at 9:27am revealed:	C 311		

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C 311	<p>Continued From page 12</p> <ul style="list-style-type: none"> -She saw roaches crawling down the wall and on the mirror in her room. -She went to bed at 8:00pm and woke up at 2:00am some nights because she felt roaches crawling on her. -When she woke up, she could not go back to sleep because she was afraid of the roaches, and her room needed to be sprayed. -She did not know what the white powdery substance was along the perimeter of her room and bathroom, and she did not know who put it down. <p>A second interview with the Resident #2 on 05/07/21 at 6:19pm revealed:</p> <ul style="list-style-type: none"> -She told the Administrator, the Supervisor-in-Charge (SIC) and her family member there were roaches in her room, and they were waking her up at night. -The Administrator told her she was going to spray. -If the Administrator could not spray, she needed to pay someone else to spray. -She had not seen anyone spray her room. -The roaches had been in her room for over a year. -She did not like the roaches, and they caused her to not be able to sleep at night. <p>Interview with the SIC on 05/07/21 at 9:42am revealed:</p> <ul style="list-style-type: none"> -She had been staying overnight at the facility since 05/03/21. -She did not know what the white powdery substance was, but she asked the Administrator who told her it was a treatment for roaches. -Resident #2 complained about roaches in the facility on 05/03/21 and on today, 05/07/21. -She knew Resident #2 had been unable to sleep one night since 05/03/21 and that was due to 	C 311		

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NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1123 CRUTCHFIELD ROAD REIDSVILLE, NC 27320
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 311	<p>Continued From page 13</p> <p>having issues with her catheter. -She did not know about any nights prior to 05/03/21.</p> <p>Interview with a representative from the pest control company on 05/07/21 at 12:38pm revealed: -Pest control services were provided quarterly at the facility. -The facility was serviced in May 2020, August 2020, November 2020, and February 2021. -The technicians treated the perimeter of the home and the inside of the home with each service visit. -The treatment was a spray for insects and pests including roaches. -She did not know what the white powdery substance was along the perimeter of the floors inside the facility. -The pest control technicians only used spray for roaches and roach gel bait. -There was a roach gel bait placed in the facility twice in 2019, but there had not been any roach gel bait placed recently. -If the facility had issues with roaches between treatments, they could reach out to the pest control company to request a service visit. -There had not been any requests for additional treatment for roaches and no treatments had been provided by the pest control company since February 2021. -The next quarterly visit was scheduled for 05/12/21.</p> <p>Interview with Resident #2's family member on 05/07/21 at 6:24pm revealed Resident #2 mentioned roaches to him, but he thought Resident #2 was talking about her old apartment.</p> <p>Interview with the Administrator on 05/07/21 at</p>	C 311		

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C 311	<p>Continued From page 14</p> <p>4:48pm revealed: -Resident #2 complained to her about the roaches and she contacted the pest control company, but she did not remember when. -The pest control company told her they would only spray the outside of the home, but it should stop roaches from entering. -She used an over the counter spray for roaches in Resident #2's room and all over the facility. -She did not know what the white powdery substance was, but one of the staff probably put the substance down along the perimeter of the walls in Resident #2's room.</p> <p>A second interview with the Administrator on 05/7/21 at 6:37pm revealed: -She sprayed for roaches in Resident #2's room and throughout the facility, but she did not remember when. -Staff reported to her a few months ago there were roaches in Resident #2's room, but she did not know Resident #2 had trouble sleeping because of the roaches.</p> <p>The facility failed to ensure 1 of 3 sampled residents was treated with consideration and dignity related to the resident being awakened at night by roaches crawling on her which resulted in the resident not being able to go back to sleep because she was afraid of the roaches. This failure was detrimental to the resident's health, safety and welfare and constitutes a Type B Violation.</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/07/21 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 21,</p>	C 311		

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C 311	Continued From page 15 2021.	C 311		
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: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner and in accordance with the facility's policy for 1 of 3 sampled residents (#1) related to a fast-acting insulin.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 07/16/20 revealed: -Diagnoses included, diabetes type 2, hearing loss, chronic obstructive pulmonary disease, schizophrenia, hyperlipidemia, hypertension, and anemia. -There was an order for Novolog flexpen, inject per sliding scale. (Novolog is used to treat type II diabetes by lowering blood sugar levels.) -The sliding scale parameters were not listed on the FL2.</p>	C 330		

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C 330	<p>Continued From page 16</p> <p>Review of a physician's orders dated 02/24/21 revealed: -There was an order to check fingerstick blood sugar (FSBS) four times daily: before meals and at bedtime. -There was an order for Novolog flexpen u-100 insulin inject 3 times daily according to sliding scale: 70-150=13units; 151-200=16units; 201-250=19units; 251-300=22units; 301-350=25units; 351-400=28units; over 401=31units.</p> <p>Interview with a representative from the facility's contracted pharmacy on 05/07/21 at 4:03pm revealed: -There was an order dated 12/23/20 for Novolog flexpen u-100 insulin inject 3 times daily according to sliding scale: 70-150=13units; 151-200=16units; 201-250=19units; 251-300=22units; 301-350=25units; 351-400=28units; over 401=31units. -There was not a separate order for FSBS, but FSBS were implied with the sliding scale order. -Five Novolog 300 unit flexpen's (1500 units) were dispensed to the facility each time on 12/23/20, 02/11/21, 03/04/21, 03/18/21, and 04/18/21.</p> <p>Review of Resident #1's Medication Administration Record (MAR) for February 2021 revealed: -There was an entry for Novolog flexpen syringe insulin inject 3 times daily at 8:00am, 12:00pm, and 5:00pm daily according to sliding scale: 70-150=13units; 151-200=16units; 201-250=19units; 251-300=22units; 301-350=25units; 351-400=28units; over 401=31units. -There was documentation Novolog was</p>	C 330		

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C 330	<p>Continued From page 17</p> <p>administered for 84 of 84 opportunities from 02/01/21 through 02/28/21.</p> <p>Review of Resident #1's handwritten insulin administration log for February 2021 revealed:</p> <ul style="list-style-type: none"> -There was documentation at the top of the log take FSBS 4 times daily. Give Novolog only at breakfast, lunch, and dinner. - There was a daily entry for the insulin type, FSBS reading, sliding scale units that should be administered, the injection site, the amount of insulin administered, and staff initials. -There was documentation Novolog was not administered according to the sliding scale for 4 of 84 opportunities. -On 02/07/21 at 8:12am, Resident #1's FSBS was documented as 150 and 16 units of Novolog were administered when 13 units should have been administered. -On 02/07/21 at 11:45am, Resident #1's FSBS was documented as 381 and 19 units of Novolog were administered when 28 units should have been administered. -On 02/10/21 at 7:10am, Resident #1's FSBS was documented as 229 and 22 units of Novolog were administered when 19 units should have been administered. -On 02/10/21 at 7:22am, Resident #1's FSBS was documented as 264 and 19 units of Novolog were administered when 22 units should have been administered. -Resident #1's FSBS ranged from 61 to 482. <p>Review of Resident #1's MAR for March 2021 revealed:</p> <ul style="list-style-type: none"> -There was an entry for Novolog flexpen syringe insulin inject 3 times daily at 8:00am, 12:00pm, and 5:00pm daily according to sliding scale: 70-150=13units; 151-200=16units; 201-250=19units; 251-300=22units; 	C 330		

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C 330	<p>Continued From page 18</p> <p>301-350=25units; 351-400=28units; over 401=31units.</p> <p>-There was documentation Novolog was administered for 93 of 93 opportunities from 03/01/21 through 03/31/21.</p> <p>Review of Resident #1's handwritten insulin administration log for March 2021 revealed:</p> <p>-There was documentation at the top of the log take FSBS 4 times daily. Give Novolog only at breakfast, lunch, and dinner.</p> <p>-There was a daily entry for the insulin type, FSBS reading, sliding scale units that should be administered, the injection site, the amount of insulin administered, and staff initials.</p> <p>-There was documentation Novolog was not administered according to the sliding scale for 4 of 93 opportunities.</p> <p>-On 03/02/21 at 5:05am, Resident #1's FSBS was documented as 340 and 16 units of Novolog were administered when 25 units should have been administered.</p> <p>-On 03/03/21 at 7:29am, Resident #1's FSBS was documented as 100 and 19 units of Novolog were administered when 13 units should have been administered.</p> <p>-On 03/14/21 at 10:52am, Resident #1's FSBS was documented as 218 and 13 units of Novolog were administered when 19 units should have been administered.</p> <p>-On 03/14/21 at 3:59am, Resident #1's FSBS was documented as 162 and 13 units of Novolog were administered when 16 units should have been administered.</p> <p>-Resident #1's FSBS ranged from 65 to 436.</p> <p>Review of Resident #1's MAR for April 2021 revealed:</p> <p>-There was an entry for Novolog flexpen syringe insulin inject 3 times daily at 8:00am, 12:00pm,</p>	C 330		

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C 330	<p>Continued From page 19</p> <p>and 5:00pm daily according to sliding scale: 70-150=13units; 151-200=16units; 201-250=19units; 251-300=22units; 301-350=25units; 351-400=28units; over 401=31units.</p> <p>-There was documentation Novolog was administered for 90 of 90 opportunities from 04/01/21 through 04/30/21.</p> <p>Review of Resident #1's handwritten insulin administration log for April 2021 revealed:</p> <p>-There was documentation at the top of the log take FSBS 4 times daily. Give Novolog only at breakfast, lunch, and dinner.</p> <p>-There was a daily entry for the insulin type, FSBS reading, sliding scale units that should be administered, the injection site, the amount of insulin administered, and staff initials.</p> <p>-There was documentation Novolog was not administered according to the sliding scale for 12 of 90 opportunities with examples as follows.</p> <p>-On 04/09/21 at 8:05am, Resident #1's FSBS was documented as 173 and 13 units of Novolog were administered when 16 units should have been administered.</p> <p>-On 04/10/21 at 12:44pm, Resident #1's FSBS was documented as 158 and 13 units of Novolog were administered when 16 units should have been administered.</p> <p>-On 04/12/21 at 8:06am, Resident #1's FSBS was documented as 195 and 13 units of Novolog were administered when 16 units should have been administered.</p> <p>-On 04/12/21 at 12:58pm, Resident #1's FSBS was documented as 265 and 19 units of Novolog were administered when 22 units should have been administered.</p> <p>-On 04/16/21 at 7:55am, Resident #1's FSBS was documented as 250 and at 9:09am, Resident #1's FSBS was documented as 135; 19 units of</p>	C 330		

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C 330	<p>Continued From page 20</p> <p>Novolog was administered, but there was no documentation if the Novolog was administered at 7:55am or at 9:09am. It could not be determined if Novolog was administered per the sliding scale.</p> <p>-On 04/29/21 at 5:01pm, Resident #1's FSBS was documented as 82 and 0 units of Novolog were administered when 13 units should have been administered.</p> <p>-On 04/30/21 at 6:55am, Resident #1's FSBS was documented as 158 and 13 units of Novolog were administered when 16 units should have been administered.</p> <p>-On 04/30/21 at 4:54pm, Resident #1's FSBS was documented as 230 and 16 units of Novolog were administered when 19 units should have been administered.</p> <p>-Resident #1's FSBS ranged from 82 to 564.</p> <p>Review of Resident #1's MAR for May 2021 revealed:</p> <p>-There was an entry for Novolog flexpen syringe insulin inject 3 times daily at 8:00am, 12:00pm, and 5:00pm daily according to sliding scale: 70-150=13units; 151-200=16units; 201-250=19units; 251-300=22units; 301-350=25units; 351-400=28units; over 401=31units.</p> <p>-There was documentation Novolog was administered for 21 of 21 opportunities from 05/01/21 through 05/07/21.</p> <p>Review of Resident #1's handwritten insulin administration log for May 2021 revealed:</p> <p>-There was documentation at the top of the log take FSBS 4 times daily. Give Novolog only at breakfast, lunch, and dinner.</p> <p>-There was a daily entry for the insulin type, FSBS reading, sliding scale units that should be administered, the injection site, the amount of</p>	C 330		

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C 330	<p>Continued From page 21</p> <p>insulin administered, and staff initials.</p> <p>-There was documentation Novolog was not administered according to the sliding scale for 3 of 21 opportunities.</p> <p>-On 05/03/21 at 7:35am, Resident #1's FSBS was documented as 195 and 13 units of Novolog were administered when 16 units should have been administered.</p> <p>-On 05/03/21 at 11:59am, Resident #1's FSBS was documented as 260 and 16 units of Novolog were administered when 22 units should have been administered.</p> <p>-On 05/04/21 at 8:26am, Resident #1's FSBS was documented as 294 and 16 units of Novolog were administered when 22 units should have been administered.</p> <p>-Resident #1's FSBS ranged from 96 to 584.</p> <p>Observation of Resident #1's medications on hand on 05/07/21 at 3:45pm revealed there were 5 pens of insulin dispensed by the pharmacy on 12/23/21 and there was 1 remaining.</p> <p>Interview with Resident #1 on 05/07/21 at 8:50am revealed:</p> <p>-She was deaf and communicated by writing.</p> <p>-She had a diagnosis of diabetes.</p> <p>-She had FSBS checks 4 times daily and was administered 2 different insulins daily.</p> <p>-She had not noticed any symptoms of low or high blood sugar levels.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 05/07/21 at 3:51pm revealed:</p> <p>-She administered medication to Resident #1 and Resident #1 was the only resident at the facility with orders for FSBS.</p> <p>-She checked Resident #1's FSBS before breakfast, lunch, and dinner before administration of her sliding scale insulin.</p>	C 330		

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C 330	<p>Continued From page 22</p> <p>-Her process for administering insulin to Resident #1 was to check her FSBS and then to look on the insulin container for the number of units to administer according to the sliding scale. She then looked back at the MAR to make sure she was administering the correct units of Novolog according to the sliding scale.</p> <p>-She administered Resident #1's sliding scale insulin on 05/04/21 at 8:06am.</p> <p>-She did not realize she administered the wrong dose of insulin to Resident #1 and must have looked at the sliding scale on the insulin box wrong.</p> <p>-"That was an error."</p> <p>-If she had realized the error, she would have called the Administrator to inform her and ask what she needed to do.</p> <p>-The Administrator was the only staff who contacted the residents' physicians.</p> <p>Interview with the Administrator on 05/07/21 at 4:48pm revealed:</p> <p>-She reviewed the MARs and the insulin administration log as she had time.</p> <p>-She had not noticed the errors in administration of insulin from February 2021 through May 2021.</p> <p>-She expected insulin to be administered to Resident #1 as ordered by her physician.</p> <p>Attempted interview with Resident #1's endocrinologist on 05/07/21 at 4:23pm was unsuccessful.</p> <p>Attempted interview with 2 other SIC's who administered insulin to Resident #1 on 05/07/21 at 4:48pm was unsuccessful.</p> <p>_____</p> <p>The facility failed to assure medications were administered to Resident #1 as ordered which resulted in the incorrect doses of sliding scale</p>	C 330		

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C 330	<p>Continued From page 23</p> <p>insulin administered 23 times which could result in the resident experiencing episodes of hypoglycemia and/or hyperglycemia. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/24/21 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 21, 2021.</p>	C 330		
C 912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to residents' rights, adult care homes medication aides training and competency, training on care of diabetic residents and medication administration.</p> <p>The findings are:</p> <p>1. Based on observations and interviews, the facility failed to ensure 1 of 3 sampled residents</p>	C 912		

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NAME OF PROVIDER OR SUPPLIER BEVERLY RUCKER'S FAMILY CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1123 CRUTCHFIELD ROAD REIDSVILLE, NC 27320
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 912	<p>Continued From page 24</p> <p>(Resident #2) was treated with consideration and dignity related to having roaches in her room and being afraid of roaches. [Refer to Tag 0311 10A NCAC 13G .0909 Residents' Rights (Type B Violation).]</p> <p>2. Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and Staff B) who administered medications had completed the medication administration competency validation clinical skills checklist (A and B), the 5, 10, or 15 hour state approved medication administration training courses, and successfully passed the written medication examination prior to administering medications (B). [Refer to Tag 0935 G.S. 131D-4.5B(b) Adult Care Home Medication Aides; Training and Competency Evaluation (Type B Violation)].</p> <p>3. Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled staff, (Staff A, B, and C), had completed training on the care of the diabetic resident prior to the administration of insulin. [Refer to Tag 0174 10A NCAC 13G .0505(1)(2) Training on Care of Diabetic Residents (Type B Violation)].</p> <p>4. Based on interviews, and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner and in accordance with the facility's policy for 1 of 3 sampled residents (#1) related to a fast-acting insulin. [Refer to Tag 0330 10A NCAC 13G .1004(a) Medication Administration (Type B Violation)].</p>	C 912		
C 934	G.S.131D-4.5B (a) ACH Infection Prevention Requirements	C 934		

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C 934	<p>Continued From page 25</p> <p>G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements</p> <p>(a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5</p> <p>This Rule is not met as evidenced by: Based on interview and record review, the facility failed to ensure the state mandated annual infection control training had been completed for 3 of 3 medication aides (Staff A, B and C).</p> <p>The findings are:</p> <p>1. Review of Staff A's, Supervisor-in-Charge (SIC) personnel record revealed: -Staff A was hired on 04/24/20. -There was no documentation Staff A completed any state mandated annual infection control trainings.</p> <p>Attempted interview with Staff A on 05/07/21 at 4:48pm was unsuccessful.</p> <p>Refer to interview with the Administrator on 05/07/21 at 4:49pm.</p>	C 934		

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C 934	<p>Continued From page 26</p> <p>2. Review of Staff B's, Supervisor-in-Charge (SIC) personnel record revealed: -There was no hire date for staff B. -There was no documentation Staff A completed any state mandated annual infection control trainings.</p> <p>Attempted interview with Staff B on 05/07/21 at 4:48pm was unsuccessful.</p> <p>Refer to interview with the Administrator on 05/07/21 at 4:49pm.</p> <p>3. Review of Staff C's, Supervisor-in-Charge (SIC) personnel record revealed: -There was no hire date for Staff C. -There was documentation Staff C completed a state mandated annual infection control training on 11/25/18. -There was no documentation Staff C completed a state mandated annual infection control training after 11/25/18.</p> <p>Interview with Staff C on 05/07/21 at 4:45pm revealed: -She was hired at the facility in 2019, but she also worked at other facilities under the same ownership. -She obtained Fingerstick Blood Sugars (FSBS) and administered insulin to the residents during her shift. -She did not remember if she had completed the annual infection control training since 2018.</p> <p>Interview with the Administrator on 05/07/21 at 4:49pm revealed: -She contracted with a nurse to complete the annual infection control trainings. -The annual infection control trainings had been completed for staff.</p>	C 934		

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C 934	Continued From page 27 -She kept the infection control training certificates were in a different file. A request was made for a copy of staff certificates for the state mandated annual infection control training but not provided prior to exit on 05/07/21.	C 934		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes	C935		

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C935	<p>Continued From page 28</p> <p>training and instruction in all of the following:</p> <ol style="list-style-type: none"> 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. <p>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and Staff B) who administered medications had completed the medication administration competency validation clinical skills checklist (A and B), the 5, 10, or 15 hour state approved medication administration training courses, and successfully passed the written medication examination prior to administering medications (B).</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. Review of Staff A's, Supervisor-in-Charge (SIC), personnel record reveled: <ul style="list-style-type: none"> -Staff was hired on 04/24/20. -There was documentation Staff A passed the written medication aide examination on 05/22/01. -There was no documentation Staff A had completed a 5, 10, or 15-hour medication administration training course. -There was no documentation there was an employment verification form completed for Staff A. 	C935		

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C935	<p>Continued From page 29</p> <p>-There was no documentation Staff A completed the medication administration competency validation clinical skills checklist.</p> <p>Review of a resident's Medication Administration Record (MAR) for March 2021 revealed: -Staff A documented administering medications including Fingerstick Blood Sugars (FSBS) and insulin for 23 days between 03/01/21 and 03/31/21. -Staff A had 1 documented insulin administration error in March 2021.</p> <p>Review of a resident's MAR for April 2021 revealed: -Staff A documented administering medications including FSBS and insulin for 20 days between 04/01/21 through 04/26/21. -Staff A had 5 documented insulin administration errors in April 2021.</p> <p>Attempted interview with Staff A on 05/07/21 at 4:48pm was unsuccessful.</p> <p>Interview with the Administrator on 05/07/21 at 4:49pm revealed: -Staff A completed the medication administration competency validation clinical skills checklist, but she did not know when. -Staff A had not completed a 5, 10, or 15-hour medication administration training course. -She was responsible for ensuring staff completed medication aide training. -She thought staff did not need the 5, 10, or 15-hour training if they passed the written medication aide examination prior to 2013.</p> <p>2. Review of Staff B's, Supervisor-in-Charge (SIC), personnel record revealed: -There was no documentation of Staff B's date of</p>	C935		

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C935	<p>Continued From page 30</p> <p>hire.</p> <p>-There was documentation Staff B completed the medication administration competency validation clinical skills checklist on 03/10/21.</p> <p>-There was no documentation Staff B passed the written medication aide examination.</p> <p>-There was no documentation Staff B completed a 5, 10, or 15-hour medication administration training course.</p> <p>Review of a resident's Medication Administration Record (MAR) for April 2021 revealed:</p> <p>-Staff B documented administering medications including FSBS and insulin for 5 days from 04/26/21 through 04/30/21.</p> <p>-Staff B had 1 documented insulin administration error in April 2021.</p> <p>Review of a resident's MAR for May 2021 revealed Staff B documented administering medications including FSBS and insulin for 3 days from 05/01/21 through 05/03/21.</p> <p>Attempted interview with Staff B on 05/07/21 at 4:48pm was unsuccessful.</p> <p>Interview with the Administrator on 05/07/21 at 4:49pm revealed:</p> <p>-She was responsible for ensuring staff medication aide training was completed.</p> <p>-Staff B had not passed the written medication aide examination and was not scheduled to take the written examination.</p> <p>-Staff B had not completed the 5, 10, or 15-hour medication administration training course.</p> <p>-Staff B completed the medication administration competency validation clinical skills checklist and she thought Staff B could pass medication as long as she completed the medication administration competency validation clinical</p>	C935		

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C935	<p>Continued From page 31</p> <p>skills checklist.</p> <p>_____</p> <p>The facility failed to ensure 2 of 3 sampled staff (Staff A and Staff B) who administered medications were competency validated, completed a 5, 10, or 15-hour state approved medication training course prior to administering medications, and passed the written medication aide examination which resulted in medication errors in the administration of insulin. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/07/21 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 21, 2021.</p>	C935		