

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL079033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY RUCKER'S FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 NE MARKET STREET REIDSVILLE, NC 27320</b>
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C 000	Initial Comments  The Adult Care Licensure Section conducted an annual survey on 05/05/21 through 05/06/21.	C 000		
C 147	<p>10A NCAC 13G .0406(a)(7) Other Staff Qualifications</p> <p>10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40;</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) had a criminal background completed upon hire.</p> <p>The findings are:</p> <p>Review of Staff A's, Supervisor-in-Charge (SIC) personnel record revealed: -Staff was hired on 05/06/20. -There was no documentation a criminal background check had been completed and no documentation of a signed consent for a criminal background check.</p> <p>Interview with Staff A on 05/05/21 at 6:54pm revealed: -She started working at the facility in 2020 as a SIC. -She did not remember having a criminal background check completed or signing a consent for a criminal background check.</p> <p>Interview with the Administrator on 05/06/21 at 2:51pm revealed:</p>	C 147		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 147	Continued From page 1  -She was responsible for completing criminal background checks before staff started working at the facility. -Staff A had worked at the facility since 2020. -She thought she had completed a criminal background check on Staff A.	C 147		
C 171	10A NCAC 13G .0504(a) Competency Validation For Licensed Health  10A NCAC 13G .0504 Competency Validation For Licensed Health Professional Support Tasks (a) A family care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.  This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled staff (Staff B) had completed a competency validation for Licensed Health Professional Support (LHPS) for tasks of administering medication by injection and monitoring fingerstick blood sugar (FSBS).  The findings are:  1. Review of Staff A's, Supervisor-in-Charge (SIC) personnel record revealed: -Staff was hired on 05/06/20. -There was no documentation Staff A had a	C 171		

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C 171	<p>Continued From page 2</p> <p>completed a competency validation for LHPS tasks.</p> <p>Review of a resident's Insulin Administration Log for for February 2021 and March 2021 revealed Staff A documented Fingerstick Blood Sugars (FSBS) and administering sliding scale insulin for 3 days between 02/01/21 and 02/28/21 and 16 days between 03/01/21 and 03/31/21.</p> <p>Interview with a resident on 05/05/21 at 9:48am revealed Staff A checked her blood sugar and administered insulin to her twice daily.</p> <p>Interview with Staff A on 05/05/21 at 6:12pm revealed: -There were two residents who had physician's orders to check FSBS and one resident was administered insulin. -She checked the resident's FSBS and administered insulin to the resident twice daily. -She did not remember if she had been checked off by a nurse for competency validation for LHPS tasks.</p> <p>Attempted interview with the facility's Registered Nurse (RN) consultant on 05/06/21 at 10:24am was unsuccessful.</p> <p>Refer to interview with the Administrator on 05/05/21 at 4:03pm.</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 hire. -There was no documentation Staff B had a completed a competency validation for LHPS tasks.</p>	C 171		

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C 171	<p>Continued From page 3</p> <p>Review of a resident's Insulin Administration Log for for February 2021 and March 2021 revealed Staff B documented Fingerstick Blood Sugars (FSBS) and administering sliding scale insulin for 9 days between 02/01/21 and 02/28/21 and 6 days between 03/01/21 and 03/31/21.</p> <p>Attempted interview with Staff B on 05/05/21 at 4:02pm was unsuccessful.</p> <p>Refer to interview with the Administrator on 05/06/21 at 2:51pm.</p> <p>3. Review of Staff C's, Supervisor-in-Charge (SIC) personnel record revealed: -There was no documentation of Staff C's date of hire. -There was no documentation Staff B had a completed a competency validation for LHPS tasks.</p> <p>Attempted interview with Staff C on 05/05/21 at 4:02pm was unsuccessful.</p> <p>Refer to interview with the Administrator on 05/06/21 at 2:51pm.</p> <p>Interview with the Administrator on 05/05/21 at 4:03pm revealed: -She was responsible for ensuring staff completed LHPS validations. -She thought staff had completed LHPS validations and they should have been in the staff's personnel records. -There was one resident who was administered insulin daily. -All staff who worked checked the residents' FSBS and administered insulin.</p>	C 171		

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C 174	Continued From page 4	C 174		
C 174	<p>10A NCAC 13G .0505(1)(2) Training On Care Of Diabetic Residents</p> <p>10A NCAC 13G .0505 Training On Care Of Diabetic Residents</p> <p>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:</p> <p>(1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner.</p> <p>(2) Training shall include at least the following:</p> <p>(a) basic facts about diabetes and care involved in the management of diabetes;</p> <p>(b) insulin action;</p> <p>(c) insulin storage;</p> <p>(d) mixing, measuring and injection techniques for insulin administration;</p> <p>(e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms;</p> <p>(f) blood glucose monitoring; universal precautions; appropriate administration times; and</p> <p>(g) sliding scale insulin administration.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 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> <p>Review of Staff C's, Supervisor-in-Charge (SIC) record revealed: -Staff A was hired on 11/30/06.</p>	C 174		

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C 174	<p>Continued From page 5</p> <p>-There was no documentation of completion of training on care of diabetic residents.</p> <p>Review of a resident's Medication Administration Record (MAR) for March 2021 revealed Staff C documented Fingerstick Blood Sugars (FSBS) and administering sliding scale insulin for 23 between 02/01/21 and 02/28/21.</p> <p>Attempted interview with Staff C on 05/05/21 at 4:02pm was unsuccessful.</p> <p>Interview with the Administrator on 05/07/21 at 4:49pm revealed:</p> <ul style="list-style-type: none"> <li>-She was responsible for ensuring staff had completed diabetic training.</li> <li>-Staff C had diabetic care training in December 2020 prior to working at the facility.</li> <li>-She did not have contact information for Staff C.</li> <li>-Staff C called her when she was ready to work.</li> <li>-She kept diabetic care training certificates in a separate notebook.</li> </ul> <p>A request was made to the Administrator for a copy of staff certificates for training on care of diabetics, but not provided prior to exit on 05/07/21.</p>	C 174		
C 246	<p>10A NCAC 13G .0902(b) Health Care</p> <p>10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to initiate referrals for 1 of 3 (Resident #2) sampled residents related to a</p>	C 246		

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C 246	<p>Continued From page 6</p> <p>recommendation by the Licensed Health Personnel Support (LHPS) registered nurse (RN) for a dental exam due to ill-fitting dentures and who needed her eyeglasses repaired.</p> <p>The findings are:</p> <p>Review of Resident #2's current FL-2 dated 02/20/21 revealed diagnoses included diabetes type II, schizophrenia, and hyperlipidemia.</p> <p>a. Review of Resident #2's LHPS review dated 11/10/20 revealed: -Resident #2 had dentures, but she did not wear them because the fit was loose. -The LHPS RN recommended Resident #2 see a dentist for proper fitting of dentures due to diagnoses of diabetes.</p> <p>Review of Resident #2's LHPS review dated 02/08/21 revealed the LHPS RN recommended Resident #2 see a dentist for proper fitting of dentures due diagnoses of diabetes.</p> <p>Telephone interview with the LHPS RN on 05/05/21 at 4:21pm revealed: -Resident #2 was diabetic. -When she assessed residents who were diabetic, she looked for a dental exam and eye exam within the past year and podiatry care as needed. -She had not seen a recent dental exam for Resident #2. -Resident #2 had dentures, but she did not wear her dentures because they were ill fitting. -She worried about diabetic residents getting sores in their mouths and their nutrition when the residents did not wear their dentures.</p> <p>Interview with Resident #2 on 05/05/21 at 3:58pm</p>	C 246		

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C 246	<p>Continued From page 7</p> <p>revealed:</p> <ul style="list-style-type: none"> <li>-She has had dentures for a while, but she had not been able to wear them because the bottom dentures were too loose.</li> <li>-She would be able to eat better if she had dentures.</li> <li>-She told the administrator her dentures were loose, but she did not remember when.</li> <li>-She had not seen a dentist since she told the administrator her dentures were loose.</li> </ul> <p>Interview with the Administrator on 05/05/21 at 4:25pm revealed:</p> <ul style="list-style-type: none"> <li>-She knew Resident #2 had dentures, but she had never seen her wear them.</li> <li>-She took Resident #2 to the dentist in 2018 and afterwards Resident #2 complained about her dentures not fitting properly.</li> <li>-She took Resident #2 back to the dentist in 2018 and she has not heard any other complaints from Resident #2 regarding her dentures since.</li> <li>-Resident #2 has not been to the dentist since 2018.</li> <li>-She was responsible for scheduling appointments for residents.</li> <li>-She did not schedule a dental appointment for Resident #2 because she did not know Resident #2 was having a problem with her dentures.</li> <li>-She reviewed the quarterly LHPS reviews, but she had no seen the LHPS RN's recommendations for a dental appointment due to ill-fitting dentures.</li> </ul> <p>b. Observation of Resident #2 on 05/05/21 at 10:01am revealed:</p> <ul style="list-style-type: none"> <li>-She was wearing prescription glasses.</li> <li>-There was tape around the joint between the frame of the lens and the right handle.</li> <li>-A portion of the tape was sticking out towards Resident #2's right eye.</li> </ul>	C 246		

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C 246	<p>Continued From page 8</p> <p>Interview with Resident #2 on 05/05/21 at 10:02am revealed:                      -Her glasses were prescription glasses.                      -The screw came out of the joint that connected the right handle of her glasses the right lens about 2 to 3 weeks ago.                      -She put tape on the joint so that the handle would stay on the glasses.                      -The tape was unraveling and stuck out towards her right eye, sometimes irritating the right eye.                      -She told the Administrator when the screw came out of her glasses and the Administrator told her she would take the glasses somewhere and get them fixed.                      -She had not seen an eye doctor, and no one had attempted to repair her glasses since the screw came out.</p> <p>Interview with the Administrator on 05/06/21 at 2:58pm revealed:                      -Resident #2 was last prescribed glasses 2 years ago and had an eye exam 1 year ago.                      -She did not know the screw came out of Resident #2's glasses and the tape holding the handle on was sometimes irritating her eyes.                      -No one told her Resident #2's glasses needed to be repaired and she did not see the tape on them until 05/05/21.                      -She would have bought an eyeglass repair kit and repaired Resident #2's glasses.</p>	C 246		
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</p>	C 330		

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C 330	<p>Continued From page 9</p> <p>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: Based on interviews, and record reviews, the facility failed to administer a medication as ordered by the licensed prescribing practitioner for 1 of 3 sampled residents (#1) related to a fast-acting insulin.</p> <p>The findings are:</p> <p>Review of Resident #3's current FL2 dated 10/14/20 revealed: -Diagnoses included diabetes type 2, blindness of both eyes, and chronic kidney disease stage 4. -There was an order for fingerstick blood sugars (FSBS) twice daily at breakfast and supper. -There was an order for Novolog mix 70/30 (a fast-acting insulin used to lower elevated blood sugar levels) give 60 units with breakfast and 40 units with supper for FSBS greater than 90.</p> <p>Review of Resident #3's Medication Administration Record (MAR) for March 2021 revealed: -There was an entry for blood sugar check and record blood glucose twice daily before breakfast and supper and scheduled for administration at 8:00am and 5:00pm. -There was documentation Resident #3's FSBS was checked twice daily from 03/01/21 through 03/31/21, but there was no documentation of the FSBS reading. -There was an entry for Novolog Mix 70/30 give 60 units with breakfast and 40 units with supper</p>	C 330		

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C 330	<p>Continued From page 10</p> <p>for blood sugar greater than 90 and scheduled for administration at 8:00am and 5:00pm.</p> <p>-There was documentation Novolog was administered from 03/01/21 through 03/31/21, but there was no documentation of how many units were administered.</p> <p>Review of Resident #3's handwritten Insulin Administration Log for March 2021 revealed:</p> <p>-Resident #3's name was written at the top of the log</p> <p>-The medication was not listed, but there was documentation to give 60 units with breakfast and 40 units with dinner if FSBS readings were greater than 90.</p> <p>-There was an entry for the date, time, FSBS reading, site, units given and initials of staff.</p> <p>-Resident #3 was administered insulin 6 of 6 times when her FSBS was less than 90 when no insulin should have been administered.</p> <p>-On 03/12/21 at 7:49am, Resident #3's FSBS was 86 and 60 units of insulin was administered when no units should have been administered.</p> <p>-On 03/21/21 at 7:55am, Resident #3's FSBS was 79 and 60 units of insulin was administered when no units should have been administered.</p> <p>-On 03/22/21 at 5:19pm, Resident #3's FSBS was 67 and 40 units of insulin was administered when no units should have been administered.</p> <p>-On 03/23/21 at 7:55am, Resident #3's FSBS was 79 and 60 units of insulin was administered when no units should have been administered.</p> <p>-On 03/26/21 at 7:55am, Resident #3's FSBS was 84 and 60 units of insulin was administered when no units should have been administered.</p> <p>-On 03/27/21 at 5:31pm, Resident #3's FSBS was 74 and 40 units of insulin was administered when no units should have been administered.</p> <p>Observation of Resident #3's medications on</p>	C 330		

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C 330	<p>Continued From page 11</p> <p>hand on 05/05/21 at 5:17pm revealed Novolog 70/30 mix was available for administration..</p> <p>Interview with Resident #3 on 05/05/21 at 9:48am revealed: -She was a diabetic -Staff checked her FSBS twice a day and she was administered insulin by staff twice a day.</p> <p>Interview with the facility's contracted pharmacy on 05/05/21 at 4:30pm revealed: -There was an active order for FSBS twice a day before breakfast and supper. (Check this sentence for accuracy) -There was an active order for Novolog 70/30 insulin 60 units with breakfast and 40 units with supper for FSBS greater than 90.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 05/05/21 at 6:12pm revealed: -She checked Resident #3's FSBS and administered Novolog insulin to her twice daily. -She administered Novolog to Resident #3 in March 2021. -The Administrator told her to administer insulin to Resident #3 regardless of what her FSBS was. -She did not see the parameters for Novolog on the Insulin Administration Log, the Medication Administration Record, or on the Novolog pharmacy packaging. -"It was an error." -She had not noticed any signs or symptoms of hypoglycemia and Resident #3 had not complained of any signs or symptoms.</p> <p>Interview with a nurse at Resident #3's Primary Care Provider's (PCP) office on 05/06/21 at 9:05am revealed: -Resident #3 had a current order for Novolog 70/30 insulin administer 60 units with breakfast</p>	C 330		

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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY RUCKER'S FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 NE MARKET STREET REIDSVILLE, NC 27320</b>
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C 330	<p>Continued From page 12</p> <p>and 40 units with supper for FSBS greater than 90.</p> <p>-The PCP did not know staff at the facility had been administering 60 units of insulin to Resident #3 when her was less than 90.</p> <p>-Novolog should not have been administered to Resident #3 when her FSBS was less than 90 because it could have caused her blood sugar to drop more.</p> <p>-There had been no reports form the facility of Resident #3 experiencing any signs or symptoms of hypoglycemia.</p> <p>Interview with the Administrator on 05/06/21 at 2:58pm revealed:</p> <p>-She did not know Novolog insulin was being administered to Resident #3 when her FSBS was less than 90.</p> <p>-She was responsible for reviewing the MARs and Insulin Administration Logs and reviewed them weekly.</p> <p>-She only looked to make sure staff documented they administered medication and did not check to see if medication, including insulin was being administered according to the order.</p> <p>-She expected staff to administer Novolog insulin as ordered by the physician and according to the parameters.</p>	C 330		
C 342	<p>10A NCAC 13G .1004(j) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following:</p> <p>(1) resident's name;</p> <p>(2) name of the medication or treatment order;</p> <p>(3) strength and dosage or quantity of</p>	C 342		

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C 342	<p>Continued From page 13</p> <p>medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed ensure the accuracy of the medication administration records (MAR) related to documenting the administration of medications during a resident's leave of absence (#1) when the medications had not been administered by staff.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 04/09//21 revealed: -Diagnoses included amputation of leg. -There was an order for oxycodone-acetaminophen 5/325mg 1 tablet every 6 hours daily as needed for pain. -There was an order for methocarbamol 500mg 1 tablet twice daily as needed for muscle spasms.</p> <p>Review of a physician's order dated 02/23/21 revealed an order for oxycodone-acetaminophen 5/325mg 1 tablet every 6 hours as needed.</p>	C 342		

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C 342	<p>Continued From page 14</p> <p>Review of a physician's order dated 03/09/21 revealed an order for oxycodone-acetaminophen 5/325mg 1 tablet twice daily as needed.</p> <p>Review of Resident #1's Medication Administration Record (MAR) for April 2021 revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for oxycodone-acetaminophen 5-325 take 1 tablet twice daily as needed for severe pain.</li> <li>-There was documentation oxycodone-acetaminophen was administered twice daily from 04/01/21 through 04/27/21 and once on 04/28/21 and there was no time of administration.</li> <li>-There was an entry for methocarbamol 500mg take 1 tablet twice daily as needed for muscle spasms.</li> <li>-There was documentation methocarbamol was administered twice daily from 04/01/21 through 04/27/21 and once on 04/28/21 and there was no time of administration.</li> <li>-There was no documentation on the MAR for either oxycodone-acetaminophen or methocarbamol from 04/28/21 through 04/30/21.</li> </ul> <p>Review of Resident #1's medication release forms for leave of absences for April 2021 revealed staff released doses of oxycodone-acetaminophen and methocarbamol for leave of absences on 04/05/21, 04/06/21, 04/08/21 through 04/14/21, 04/17/21 through 04/22/21, 04/25/21, 04/27/21 through 04/30/21.</p> <p>Review of Resident #1's MAR for May 2021 on 05/05/21 revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for oxycodone-acetaminophen 5-325 take 1 tablet twice daily as needed for severe pain.</li> </ul>	C 342		

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C 342	<p>Continued From page 15</p> <p>-There was documentation oxycodone-acetaminophen was administered twice daily from 05/01/21 through 05/07/21 and there was no time of administration.</p> <p>-There was an entry for methocarbamol 500mg take 1 tablet twice daily as needed for muscle spasms.</p> <p>-There was documentation methocarbamol was administered twice daily from 05/01/21 through 05/07/21 and there was no time of administration.</p> <p>Review of Resident #1's medication release forms on 05/05/21 for leave of absences for May 2021 revealed staff released doses of oxycodone-acetaminophen and methocarbamol for leave of absences on 05/01/21 through 05/03/21 and 05/05/21 through 05/07/21.</p> <p>Interview with Resident #1 on 05/05/21 at 2:39pm revealed:</p> <p>-He had physician's orders for oxycodone-acetaminophen and methocarbamol twice daily as needed.</p> <p>-He left the facility and returned several days a week.</p> <p>-He had taken leave of absences in April 2021, May 2021 and was getting ready to leave today on 05/05/21.</p> <p>-Sometimes he was administered his medication prior to leaving the facility, but he always took doses of oxycodone-acetaminophen and methocarbamol with him when he left the facility on leave of absences.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 05/05/21 at 6:12pm revealed:</p> <p>-Resident #1 was out of the facility 3 to 5 days a week.</p> <p>-When Resident #1 was at the facility and she administered medications to him and</p>	C 342		

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C 342	<p>Continued From page 16</p> <p>documented her initials on the MAR.</p> <p>-When Resident #1 was not at the facility, she documented an "O" for "out of facility," but she did not document on the back of the MAR the reason why "O" was documented.</p> <p>-She did not know why the MARs for April 2021 and May 2021 were documented with her initials instead of an "O" when Resident #1 was on a leave of absence or why there was no documentation Resident #1 was out of the facility on a leave of absence.</p> <p>Interview with the Administrator on 05/05/21 at 1:06pm revealed:</p> <p>-She took over administering oxycodone-acetaminophen and methocarbamol to Resident #1 in April 2021.</p> <p>-Resident #1 was away from the facility almost every day on leave of absences and she was the one who released the oxycodone-acetaminophen and the methocarbamol to him for his leave of absences.</p> <p>-When she released the medication to Resident #1, she documented her initials on the MAR for each day he was to be out of the facility.</p> <p>-She knew she was supposed to document her initials on the MAR when she administered the medication, but she did not know what to do to document when she released medication to Resident #1.</p> <p>-She understood that documenting her initials on the MAR meant that she administered the medication to Resident #1.</p> <p>-She needed to make sure the SIC was not documenting the medication was administered when the medications were released to Resident #1 rather than administered.</p>	C 342		

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C 367	Continued From page 17	C 367		
C 367	<p>10A NCAC 13G .1008(a) Controlled Substances</p> <p>10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure records of the receipt and administration of controlled substances were maintained, accurate, and reconciled for 1 of 1 sampled resident (Resident #1) with an order for a narcotic for severe pain.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 04/09/21 revealed: -Diagnoses included amputation of leg. -There was a medication order for oxycodone-acetaminophen 5/325mg (used to treat severe pain) 1 tablet twice daily as needed.</p> <p>Review of a physician's order dated 01/18/21 revealed an order for oxycodone-acetaminophen 5/325mg 1 table every 6 hours as needed.</p> <p>Review of a physician's order dated 02/23/21 revealed an order for oxycodone-acetaminophen 5/325mg 1 tablet every 6 hours as needed.</p> <p>Review of a physician's order dated 03/09/21 revealed an order for oxycodone-acetaminophen 5/325mg 1 tablet twice daily as needed.</p>	C 367		

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C 367	<p>Continued From page 18</p> <p>Observation of Resident #1's medications available for administration on 05/05/21 at 1:44pm revealed: -Oxycodone-acetaminophen 1 tablet twice daily as needed was available. -There were 21 tablets dispensed to the facility on 04/27/21 and 1 tablet was remaining.</p> <p>Review of Resident #1's Medication Administration Record (MAR) for February 2021 revealed: -There was an entry for oxycodone-acetaminophen 5/325mg 1 tablet every 6 hours as needed for severe pain. -There was no documentation oxycodone-acetaminophen 5/325mg was administered between 02/01/21 and 02/28/21.</p> <p>Review of the Resident #1's handwritten, undated controlled substance count sheets (CSCS) revealed: -There was documentation of oxycodone-acetaminophen 5/325mg take 1 tablet every 6 hours as need for pain and there was a quantity of 21 tablets. -There was no date the tablets were dispensed by the pharmacy and no prescription number on the CSCS. -There was an entry for date, time, reason, amount left, amount given and the initial of the medication aide (MA). -There was documentation 21 tablets of oxycodone-acetaminophen 5/325mg were signed out between 01/28/21 at 4:00pm and 02/04/21 at 8:00am.</p> <p>Review of the Resident #1's handwritten, undated controlled substance count sheets (CSCS) revealed:</p>	C 367		

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C 367	<p>Continued From page 19</p> <ul style="list-style-type: none"> <li>-There was documentation of oxycodone-acetaminophen 5/325mg take 1 tablet every 6 hours as need for pain and there was a quantity of 30 tablets.</li> <li>-There was no date the tablets were dispensed by the pharmacy and no prescription number on the CSCS.</li> <li>-There was an entry for time, date, amount given, amount left, and the initial of the MA.</li> <li>-There was documentation 30 tablets of oxycodone-acetaminophen 5/325mg were signed out between 02/06/21 at 4:00pm and 02/13/21 at 8:00pm.</li> <li>-On 02/10/21 there was documentation 1 tablet oxycodone-acetaminophen 5/325mg was signed out at 8:00pm and 10:00pm (not 6 hours apart).</li> <li>-On 02/11/21 there was documentation 1 tablet oxycodone-acetaminophen 5/325mg was signed out at 8:00pm and 10:00pm (not 6 hours apart).</li> <li>-On 02/12/21 there was documentation 1 tablet oxycodone-acetaminophen 5/325mg was signed out at 8:00pm and 10:00pm (not 6 hours apart).</li> </ul> <p>There was no CSCS with documentation of administration of oxycodone-acetaminophen 5/325mg between 02/13/21 and 02/28/21.</p> <p>Review of Resident #1's MAR for March 2021 revealed:</p> <ul style="list-style-type: none"> <li>-There was an entry for oxycodone-acetaminophen 5/325mg 1 tablet every 6 hours as needed for severe pain.</li> <li>-There was no documentation oxycodone-acetaminophen 5/325mg 1 tablet every 6 hours as needed had been administered and "discontinued 03/09/21" had been written on the MAR on the entry.</li> <li>-There was a second entry for oxycodone-acetaminophen 5/325mg 1 tablet twice daily as needed for severe pain.</li> </ul>	C 367		

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C 367	<p>Continued From page 20</p> <p>-There was documentation oxycodone-acetaminophen 5/325mg was administered twice daily from 03/08/21 through 03/17/21, once on 03/18/21, and twice daily from between 03/19/21 and 03/31/21.</p> <p>Review of the Resident #1's undated pharmacy generated CSCS for March 2021 revealed:</p> <p>-There was no dated prescription label from the pharmacy.</p> <p>-There was documentation of oxycodone-acetaminophen 5/325mg take 1 tablet every 8 hours as need for pain and there was a quantity of 21 tablets.</p> <p>-There was no date the tablets were dispensed by the pharmacy and no prescription number on the CSCS.</p> <p>-There was an entry for date, time, dose, balance, comment, and the initial of the medication aide (MA).</p> <p>-There was documentation 21 tablets of oxycodone-acetaminophen 5/325mg were signed out between 03/03/21 at 5:00pm and 03/10/21 at 8:00am.</p> <p>-On 03/04/21, there was documentation 1 tablet of oxycodone-acetaminophen 5/325mg was signed out at 5:00pm and 8:00pm (not 8 hours apart).</p> <p>-On 03/05/21, there was documentation 1 tablet of oxycodone-acetaminophen 5/325mg was signed out at 5:00pm and 11:00pm (not 8 hours apart).</p> <p>-On 03/06/21, there was documentation 1 tablet of oxycodone-acetaminophen 5/325mg was signed out at 5:00pm and 11:00pm (not 8 hours apart).</p> <p>-On 03/07/21, there was documentation 1 tablet of oxycodone-acetaminophen 5/325mg was signed out at 5:00pm and 11:00pm (not 8 hours apart).</p>	C 367		

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C 367	<p>Continued From page 21</p> <p>-On 03/08/21, there was documentation 1 tablet of oxycodone-acetaminophen 5/325mg was signed out at 5:00pm and 11:00pm (not 8 hours apart).</p> <p>-On 03/09/21, there was documentation 1 tablet of oxycodone-acetaminophen 5/325mg was signed out at 5:00pm and 11:00pm (not 8 hours apart).</p> <p>Review of a second undated pharmacy generated CSCS for Resident #1 for March 2021 revealed:</p> <p>-There was a prescription label from the pharmacy which documented Resident #1's name and the order for oxycodone-acetaminophen 5/325mg take 1 tablet twice daily as needed for severe pain.</p> <p>-There were 21 tablets dispensed, but the date had been blackened out.</p> <p>-There was an entry for date, time, dose, balance, comment, and the initial of the medication aide (MA).</p> <p>-There was documentation 21 tablets of oxycodone-acetaminophen 5/325mg were signed out between 03/08/21 at 7:00am and 03/18/21 at 8:00pm.</p> <p>-There was documentation 1 tablet was signed out on 03/08/21 at 7:00am and 8:00pm. (The first CSCS for March 2021 documented of oxycodone-acetaminophen was signed out on 03/08/21 at 8:00am, 5:00pm and 11:00pm.)</p> <p>-There was documentation 1 tablet was signed out on 03/09/21 at 7:50am and 8:30pm. (The first CSCS for March 2021 documented oxycodone-acetaminophen was signed out on 03/09/21 at 8:00am, 5:00pm and 11:00pm.)</p> <p>-There was documentation 1 tablet was signed out on 03/10/21 at 7:15am and 9:00pm. (The first CSCS for March 2021 documented oxycodone-acetaminophen signed out on 03/10/21 at 8:00am.)</p>	C 367		

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C 367	<p>Continued From page 22</p> <p>Review of Resident #1's MAR on 05/05/21 for May 2021 revealed: -There was an entry for oxycodone-acetaminophen 5/325mg 1 tablet twice daily as needed for severe pain. -There was documentation oxycodone-acetaminophen 5/325mg 1 tablet twice daily as needed had been administered twice daily from 05/01/21 through 05/07/21.</p> <p>Review of the Resident #1's pharmacy generated CSCS on 05/05/21 for May 2021 revealed: -There was no prescription label from the pharmacy. -There was documentation of oxycodone-acetaminophen 5/325mg take 1 tablet twice daily as need for severe pain and there was a quantity of 21 tablets. -There was no date the tablets were dispensed by the pharmacy and no prescription number on the CSCS. -There was an entry for date, time, dose, balance, and the initial of the medication aide (MA). -There was documentation 20 tablets of oxycodone-acetaminophen 5/325mg were signed out between 04/28/21 and 05/07/21. In the time entry slot was written documentation of "out of facility, he took with him" and a line was drawn from the entry on 04/28/21 down through 05/07/21. -There was documentation 1 tablet of oxycodone-acetaminophen was signed out twice on 05/05/21, 05/06/21, and 05/07/21.</p> <p>Observation of Resident #1's medications available for administration on 05/05/21 at 1:44pm revealed: -Oxycodone-acetaminophen 1 tablet twice daily as needed was available.</p>	C 367		

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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY RUCKER'S FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 NE MARKET STREET REIDSVILLE, NC 27320</b>
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C 367	<p>Continued From page 23</p> <p>-There were 21 tablets dispensed to the facility on 04/27/21 and 1 tablet was remaining.</p> <p>Interview with the facility's contracted pharmacy on 05/05/21 at 12:04pm revealed:</p> <p>-The pharmacy started filling prescriptions for Resident #1 on 02/23/21.</p> <p>-On 02/23/21, oxycodone-acetaminophen 5/325mg 1 tablet every 6 hours as needed for severe pain was dispensed to the facility with a quantity of 30 tablets.</p> <p>-On 03/03/21 there was an order for oxycodone-acetaminophen 5/325mg 1 tablet every 8 hours as needed for severe pain and was dispensed to the facility on 03/03/21 with a quantity of 21 tablets.</p> <p>-On 03/09/21, there was an order for oxycodone-acetaminophen 5/325mg 1 tablet twice daily as needed for severe pain and was dispensed to the facility on 03/09/21 wit a quantity of 21 tablets.</p> <p>-There were 21 tablets of oxycodone-acetaminophen 5/325mg dispensed to the facility on 03/19/21, 03/30/21, 04/07/21, 04/15/21, and 04/27/21.</p> <p>-Resident #1 needed a new prescription to refill oxycodone-acetaminophen 5/325mg ongoing.</p> <p>Interview with Resident #1 on 05/05/21 at 11:43am revealed:</p> <p>-He had a prescription for oxycodone-acetaminophen 5/325mg twice daily as needed.</p> <p>-He took oxycodone-acetaminophen 5/325mg twice daily most days due to pain.</p> <p>-He used to take oxycodone-acetaminophen 5/325mg three times a day, but it was changed to twice daily in March 2021.</p> <p>-There were some days when he received oxycodone-acetaminophen 5/325mg prior to the</p>	C 367		

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C 367	<p>Continued From page 24</p> <p>scheduled time frame because medication could be administered 1 hour ahead of schedule.</p> <p>-He did not remember taking oxycodone-acetaminophen 5/325mg sooner than 1 hour ahead of the scheduled time frame.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 05/05/21 at 11:52am revealed:</p> <p>-She did not know why medications that were documented as signed out on the CSCS were not documented as administered on the MAR.</p> <p>-She did not know why oxycodone-acetaminophen 5/325mg was documented as administered prior to the ordered time frame of every 6 hours or every 8 hours.</p> <p>-She did not know why there were 2 CSCS with documentation of administration of oxycodone-acetaminophen on both sheets for 03/08/21, 03/09/21, and 03/10/21.</p> <p>-She did not know where the CSCS for 02/13/21 through 02/28/21 was.</p> <p>-She thought she administered oxycodone-acetaminophen 5/325 as ordered.</p> <p>Interview with the Administrator on 05/05/21 at 11:43am revealed:</p> <p>-Resident #1 had an order for oxycodone-acetaminophen 5/325mg twice daily as needed.</p> <p>-She started administering the oxycodone-acetaminophen 5/325mg at the end of April 2021.</p> <p>-She signed medications out on the CSCS and she also documented her initials on the MAR when oxycodone-acetaminophen 5/325mg was administered or released to Resident #1 for a leave of absence.</p> <p>-She documented Resident #1's medication as signed out from 05/06/21 through 05/07/21 on the CSCS and documented as administered on the</p>	C 367		

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C 367	<p>Continued From page 25</p> <p>May 2021 MAR because Resident #1 was taking a leave of absence and she did not know how else to document.</p> <p>-She did not know the SIC had signed out oxycodone-acetaminophen 5/325mg on 2 different CSCS at different times on 03/08/21, 03/09/21, and 03/10/21.</p> <p>-There should have only been documentation of oxycodone-acetaminophen 5/325mg signed out on 1 CSCS for 03/08/21, 03/09/21, and 03/10/21.</p> <p>Attempted interview with Resident #1's Primary Care Physician (PCP) on 05/05/21 at 2:21pm was unsuccessful.</p>	C 367		
C935	<p>G.S. § 131D-4.5B (b) ACH Medication Aides; Training and Competency</p> <p>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.</p> <p>(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:</p> <p>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:</p> <ol style="list-style-type: none"> <li>a. The key principles of medication administration.</li> <li>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</li> </ol>	C935		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL079033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2021</b>
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C935	<p>Continued From page 26</p> <p>exists.</p> <p>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.</p> <p>(3) Within 60 days from the date of hire, the individual must have completed the following:</p> <p>a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:</p> <ol style="list-style-type: none"> <li>1. The key principles of medication administration.</li> <li>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.</li> </ol> <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: Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled staff (Staff A, Staff B and Staff C) who administered medications had completed the 5, 10, or 15-hour state approved medication administration training courses or completed an employment verification form.</p> <p>The findings are:</p> <ol style="list-style-type: none"> <li>1. Review of Staff A's, Supervisor-in-Charge (SIC) personnel record revealed: <ul style="list-style-type: none"> <li>-Staff was hired on 05/06/20.</li> <li>-There was documentation Staff A passed the written medication examination on 11/03/00.</li> <li>-There was documentation Staff A completed the medication competency validation clinical skills checklist on 07/01/20.</li> <li>-There was no documentation Staff A completed</li> </ul> </li> </ol>	C935		
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C935	<p>Continued From page 27</p> <p>an employment verification form. -There was no documentation Staff A had completed a 5, 10, or 15-hour medication training course.</p> <p>Review of a resident's Medication Administration Record (MAR) for February 2021 and March 2021 revealed Staff A documented medication administration for 3 days in February 2021 and and 16 days in March 2021.</p> <p>Interview with Staff A on 05/05/21 at 6:54pm revealed: -She started working at the facility in 2020 as a SIC. -She was not sure if she completed a 5, 10, or 15-hour state approved medication administration training course.</p> <p>Refer to interview with the Administrator on 05/06/21 at 2:51pm.</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 hire. -There was documentation Staff B completed the medication competency validation clinical skills checklist on 10/11/06. -There was documentation Staff B passed the written medication aide examination on 02/13/06. -There was no documentation Staff B completed an employment verification form. -There was no documentation Staff B completed a 5, 10, or 15-hour medication training course.</p> <p>Review of a resident's MAR for February 2021 and March 2021 revealed Staff B documented medication administration for 9 days in February 2021 and 6 days in March 21.</p>	C935		

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C935	<p>Continued From page 28</p> <p>Attempted interview with Staff B on 05/05/21 at 4:02pm was unsuccessful.</p> <p>Refer to interview with the Administrator on 05/06/21 at 2:51pm.</p> <p>3. Review of Staff C's, Supervisor-in-Charge (SIC) personnel record revealed:</p> <ul style="list-style-type: none"> <li>-There was no documentation of Staff C's date of hire.</li> <li>-There was documentation Staff C completed the medication competency validation clinical skills checklist on 10/15/07.</li> <li>-There was documentation Staff C passed the written medication aide examination on 12/14/04.</li> <li>-There was no documentation Staff C completed an employment verification form.</li> <li>-There was no documentation Staff C completed a 5, 10, or 15-hour medication training course.</li> </ul> <p>Review of a resident's Medication Administration Record (MAR) for February 2021 revealed Staff C documented medication administration for 21 days.</p> <p>Attempted interview with Staff C on 05/05/21 at 4:02pm was unsuccessful.</p> <p>Refer to interview with the Administrator on 05/06/21 at 2:51pm.</p> <p>_____ Interview with the Administrator on 05/06/21 at 2:51pm revealed:</p> <ul style="list-style-type: none"> <li>-Staff had not completed a 5, 10, or 15-hour medication training course.</li> <li>-She was responsible for ensuring staff medication training was completed.</li> <li>-She thought staff had been "grandfathered" in for the 5, 10, or 15-hour medication training course</li> </ul>	C935		

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C935	Continued From page 29  because staff passed the written medication examination prior to 2013. -She did not know the 5, 10, or 15-hour state approved medication administration training course or an employment verification form was needed for staff.	C935		
C936	10A NCAC 13G .1010(d) (e) Pharmaceutical Servoces  10A NCAC 13G .1010 (d) (e) Pharmaceutical Services  (d) The facility shall assure the provision of medication for residents on temporary leave from the facility or involved in day activities out of the facility. The facility shall have written policies and procedures for a resident's temporary leave of absence. The policies and procedures shall facilitate safe administration by assuring that upon receipt of the medication for a leave of absence the resident or the person accompanying the resident is able to identify the medication, dosage, and administration time for each medication provided for the temporary leave of absence. The policies and procedures shall include at least the following provisions: (1) The amount of resident's medications provided shall be sufficient and necessary to cover the duration of the resident ' s absence. For the purposes of this Rule, sufficient and necessary means the amount of medication to be administered during the leave of absence or only a current dose pack, card, or container if the current dose pack, card, or container has enough medication for the planned absence; (2) Written and verbal instructions for each medication to be released for the resident's absence shall be provided to the resident or the	C936		

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C936	<p>Continued From page 30</p> <p>person accompanying the resident upon the medication ' s release from the facility and shall include at least:</p> <p>(A) the name and strength of the medication;</p> <p>(B) the directions for administration as prescribed by the resident's physician;</p> <p>(C) any cautionary information from the original prescription package if the information is not on the container released for the leave of absence;</p> <p>(3) The resident's medication shall be provided in a capped or closed container that will protect the medications from contamination and spillage; and</p> <p>(4) Labeling of each of the resident's individual medication containers for the leave of absence shall be legible, include at least the name of the resident and the name and strength of the medication, and be affixed to each container. The facility shall maintain documentation in the resident's record of medications provided for the resident's leave of absence, including the quantity released from the facility and the quantity returned to the facility. The documentation of the quantities of medications released from and returned to the facility for a resident's leave of absence shall be verified by signature of the facility staff and resident or the person accompanying the resident upon the medications ' release from and return to the facility.</p> <p>(e) The facility shall assure that accurate records of the receipt, use, and disposition of medications are maintained in the facility and available upon request for review.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the provision of medications for leaves of absences facilitated</p>	C936		

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C936	<p>Continued From page 31</p> <p>safe administration for 1 of 1 sampled resident (#1) and failed to ensure documentation of the medications, medication dosage, directions, quantity of medications released and the quantity of medications returned to the facility.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL2 dated 04/09/21 revealed:</p> <ul style="list-style-type: none"> <li>-Diagnoses included amputation of leg.</li> <li>-There was an order for fluoxetine 20mg 1 tablet daily (used to treat depression).</li> <li>-There was an order for gabapentin 300mg 1 tablet three times daily (used to treat pain).</li> <li>-There was an order for oxycodone-acetaminophen 5/325mg 1 tablet twice daily as needed (used to treat severe pain).</li> <li>-There was an order for albuterol 2 puffs into the lungs every 6 hours as needed (used to treat wheezing or shortness of breath).</li> <li>-There was an order for gavalax powder mix 1 capful in 8 ounces of water, juice, or drink once daily as needed (used to treat constipation).</li> <li>-There was an order for methocarbamol 500mg 1 tablet twice daily as needed (used to treat muscle spasms).</li> </ul> <p>Review of Resident #1's physician's orders dated 01/18/21</p> <ul style="list-style-type: none"> <li>-There was an order for Senna 8.6mg 1 tablet twice daily (used to treat constipation).</li> <li>-There was an order for Zofran 40mg 1 tablet every 8 hours as needed (used to treat nausea).</li> </ul> <p>Review of Resident #1's physician's orders dated 01/28/21 revealed an order for vitamin B12 1000mg 1 tablet daily.</p> <p>Review of a physician's order dated 02/23/21</p>	C936		

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C936	<p>Continued From page 32</p> <p>revealed an order for oxycodone with acetaminophen 5/325mg 1 tablet every 6 hours as needed.</p> <p>Review of a physician's order dated 03/09/21 revealed an order for oxycodone with acetaminophen 5/325mg 1 tablet twice daily as needed.</p> <p>Observation of Resident #1's medications available for administration on 05/05/21 at 11:36am and 1:44pm revealed fluoxetine 20mg 1 tablet daily, gabapentin 300mg, oxycodone-acetaminophen 5/325mg, albuterol 2 puffs, gavalax powder, methocarbamol 500mg, Senna 8.6mg, Zofran 4mg and vitamin B12 1000mg were available for administration.</p> <p>Review of a physician's order dated 03/09/21 revealed an order for oxycodone with acetaminophen 5/325mg 1 tablet twice daily as needed.</p> <p>Review of a handwritten medication release form dated 04/02/21 revealed:</p> <ul style="list-style-type: none"> <li>-There was no departure and return date.</li> <li>-There were 12 tablets of gabapentin, 8 tablets of Senna, 4 tablets of fluoxetine, 4 tablets of Vitamin B12, 5 tablets of methocarbamol, and 7 tablets of oxycodone-acetaminophen released to Resident #1.</li> <li>-There was no documentation of the directions for use of the released medications.</li> <li>-There was documentation Resident #1 signed the medication release form indicating he was totally responsible for the medications and he had received the medications in his hands.</li> <li>-There was no documentation any other medications were released to Resident #1 and</li> </ul>	C936		

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C936	<p>Continued From page 33</p> <p>there was no documentation any medications were returned to the facility.</p> <p>Review of a completed Medication Release Form for Resident Leave of Absence dated 04/05/21 revealed: -Resident #1 was to depart of 04/05/21 and return on 04/06/21. -There were 2 tablets of fluoxetine, 2 tablets of vitamin B12, 3 tablets of gabapentin, 1 tablet of Senna, 3 tablet of oxycodone-acetaminophen, and 3 tablets of methocarbamol released to Resident #1. -There was no documentation of the directions for use of the released medications. -There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</p> <p>Review of a handwritten note signed by Resident #1 on 04/08/21 revealed: -Resident #1 was to depart on 04/08/21 and return on 04/09/21. -There were 4 tablets of oxycodone-acetaminophen and 4 tablets of methocarbamol released to Resident #1. -There was no documentation of the directions for use of the released medications. -There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</p> <p>Review of a handwritten note signed by Resident #1 on 04/09/21 revealed: -Resident #1 was to depart on 04/09/21, but there was no return date. -There were 4 tablets of oxycodone-acetaminophen and 4 tablets of</p>	C936		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL079033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY RUCKER'S FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 NE MARKET STREET</b> <b>REIDSVILLE, NC 27320</b>
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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
C936	<p>Continued From page 34</p> <p>methocarbamol released to Resident #1. -There was no documentation of the directions for use of the released medications. -Resident #1 was responsible for himself and his medications. -There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</p> <p>Review of a handwritten note signed by Resident #1 on 04/10/21 revealed: -Resident #1 was to depart on 04/10/21 and return on 04/11/21 at or after 8:00pm. -There were 2 tablets of oxycodone-acetaminophen and 2 tablets of methocarbamol released to Resident #1. -There was no documentation of the directions for use of the released medications. -There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</p> <p>Review of a handwritten note signed by Resident #1 on 04/11/21 revealed: -There was documentation Resident #1 had his medication for 04/12/21 because he would not be back at the facility until the night of 04/12/21. -There were 2 tablets of oxycodone-acetaminophen and 2 tablets of methocarbamol released to Resident #1 for 04/12/21. -There was no documentation of the directions for use of the released medications. -There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</p>	C936		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL079033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY RUCKER'S FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 NE MARKET STREET REIDSVILLE, NC 27320</b>
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C936	<p>Continued From page 35</p> <p>Review of a handwritten note signed by Resident #1 on 04/12/21 revealed: -Resident #1 was to depart on 04/12/21 and would return after 9:00pm on 04/13/21. -There were 2 tablets of oxycodone-acetaminophen and 2 tablets of methocarbamol released to Resident #1. -There was no documentation of the directions for use of the released medications. -There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</p> <p>Review of a handwritten note signed by Resident #1 on 04/14/21 revealed: -There was documentation Resident #1 would be out of the facility on the night of 04/14/21. -There were 2 tablets of oxycodone-acetaminophen and 2 tablets of methocarbamol released to Resident #1. -There was no documentation of the directions for use of the released medications. -Resident #1 was responsible for himself and his medications. -There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</p> <p>Review of a handwritten note signed by Resident #1 on 04/16/21 revealed: -There was no documentation of a departure or return date. -There were 2 tablets of oxycodone-acetaminophen and 2 tablets of methocarbamol released to Resident #1. -There was no documentation of the directions for use of the released medications. -There was no documentation any other</p>	C936		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL079033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY RUCKER'S FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 NE MARKET STREET</b> <b>REIDSVILLE, NC 27320</b>
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C936	<p>Continued From page 36</p> <p>medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</p> <p>Review of a completed Medication Release Form for Resident Leave of Absence dated 04/16/21 revealed:</p> <ul style="list-style-type: none"> <li>-Resident #1 was to depart of 04/16/21 and return on 04/20/21.</li> <li>-There were 4 tablets of fluoxetine and 12 tablets of gabapentin released to Resident #1.</li> <li>-There was no documentation of the directions for use of the released medications.</li> <li>-There was documentation oxycodone-acetaminophen was released, but there was no documentation of the quantity released.</li> <li>-There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</li> </ul> <p>Review of a handwritten note signed by Resident #1 on 04/16/21 revealed:</p> <ul style="list-style-type: none"> <li>-There was documentation Resident #1 picked up medication on 04/16/21 for administration on 04/17/21 through 04/22/21</li> <li>-There were 12 tablets of oxycodone-acetaminophen and 12 tablets of methocarbamol released to Resident #1.</li> <li>-There was no documentation of the directions for use of the released medications.</li> <li>-There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</li> </ul> <p>Review of a handwritten note signed by Resident #1 on 04/25/21 revealed:</p> <ul style="list-style-type: none"> <li>-There was no documentation of a departure or</li> </ul>	C936		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL079033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY RUCKER'S FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 NE MARKET STREET</b> <b>REIDSVILLE, NC 27320</b>
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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
C936	<p>Continued From page 37</p> <p>return date.</p> <p>-There were 2 tablets of oxycodone-acetaminophen and 2 tablets of methocarbamol released to Resident #1.</p> <p>-There was no documentation of the directions for use of the released medications.</p> <p>-There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</p> <p>Review of a handwritten note signed by Resident #1 on 04/27/21 revealed:</p> <p>-There was documentation Resident #1 would be out of the facility on the night of 04/27/21.</p> <p>-There were 2 tablets of oxycodone-acetaminophen and 2 tablets of methocarbamol released to Resident #1.</p> <p>-There was no documentation of the directions for use of the released medications.</p> <p>-There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</p> <p>Review of a handwritten note signed by Resident #1 on 04/28/21 revealed:</p> <p>-There was documentation Resident #1 would be out of the facility "for the next day."</p> <p>-There were 6 tablets of oxycodone-acetaminophen and 6 tablets of methocarbamol released to Resident #1.</p> <p>-Resident #1 had enough medication for 04/28/21 through 04/30/21."</p> <p>-There was no documentation of the directions for use of the released medications.</p> <p>-There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</p>	C936		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL079033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY RUCKER'S FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 NE MARKET STREET REIDSVILLE, NC 27320</b>
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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
C936	<p>Continued From page 38</p> <p>Review of a handwritten note signed by Resident #1 on 04/29/21 revealed: -There was documentation Resident #1 would need medication for 05/01/21 through 05/03/21. -There were 6 tablets of oxycodone-acetaminophen and 6 tablets of methocarbamol released to Resident #1. -There was no documentation of the directions for use of the released medications. -Resident #1 was capable of taking his own medications. -There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</p> <p>Review of a handwritten note signed by Resident #1 on 05/05/21 revealed: -Resident #1 was to depart of 05/05/21 and return on 05/07/21. -There were 4 tablets of oxycodone-acetaminophen and 4 tablets of methocarbamol released to Resident #1. -There was no documentation of the directions for use of the released medications. -Resident #1 was capable of taking his own medications. -There was no documentation any other medications were released to Resident #1 and there was no documentation any medications were returned to the facility.</p> <p>Interview with Resident #1 on 05/05/21 at 11:14am revealed: -He left the facility weekly and stayed with a friend. -He took his medications with him when he left, but he did not take all of them. -He only took the medications he felt he needed.</p>	C936		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>FCL079033</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/06/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY RUCKER'S FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 NE MARKET STREET REIDSVILLE, NC 27320</b>
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C936	<p>Continued From page 39</p> <p>-He told his physician he did not take some of his medications.</p> <p>Interview with Resident #1 on 05/06/21 at 2:48pm revealed:</p> <p>-When he left the facility for a leave of absence, his medications were punched out of the pharmacy packaging and all medications were given to him in one plastic sandwich bag.</p> <p>-The medications were not labeled for identification, but he knew what his medications were by looking at them.</p> <p>-He normally took 3 to 4 pills with him including gabapentin, fluoxetine, Senna, oxycodone-acetaminophen, and methocarbamol.</p> <p>-He signed off on receiving oxycodone-acetaminophen and methocarbamol, but he did was not asked to sign off on other scheduled medications.</p> <p>-He did not take his inhaler or other as needed medications with him because he did not feel that he needed them.</p> <p>-He sometimes brought medication back to the facility and asked staff to put it back up.</p> <p>-His friend, who was a nurse, administered his medications to him.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 05/05/21 at 2:50pm revealed:</p> <p>-She had not completed any medication sign out forms when Resident #1 left the facility for a leave of absence.</p> <p>-Sometimes Resident #1 refused to take some of his medications with him when he left the facility and she told the Administrator.</p> <p>-The Administrator was responsible for contacting the PCP.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 05/06/21 at 2:37pm</p>	C936		

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY RUCKER'S FAMILY CARE HOME #2</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>503 NE MARKET STREET REIDSVILLE, NC 27320</b>
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C936	<p>Continued From page 40</p> <p>-When she prepared medications for Resident #1 to take with him on a leave of absence, she punched the medication out of the pharmacy packaging and put all the medication in one zip lock bag unlabeled.</p> <p>-She told Resident #1 what medications were in the zip lock bag, but she did not write down the medication name, dosage, or directions for Resident #1 to reference while he was out of the facility.</p> <p>"He knows his medicines better than I do."</p> <p>Interview with the Administrator on 05/06/21 at 2:58pm revealed:</p> <p>-She administered Resident #1's oxycodone-acetaminophen and methocarbamol and prepared only those two medications to send with Resident #1 on his leave of absences.</p> <p>-When she prepared the medications for Resident #1's leave of absences, she punched out each of the medications from the pharmacy packaging and placed the oxycodone-acetaminophen in one zip lock bag and the methocarbamol in another zip lock bag.</p> <p>-She wrote the name of the medication and the dosage on a sheet of paper and put the paper in inside the zip lock bags.</p> <p>-She did not write down the directions for administration.</p> <p>-She did not know how staff were preparing medications to be sent with Resident #1 on leave of absences.</p>	C936		

**STATE FORM: REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER FCL079033	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 5/6/2021
NAME OF FACILITY BEVERLY RUCKER'S FAMILY CARE HOME #2	STREET ADDRESS, CITY, STATE, ZIP CODE 503 NE MARKET STREET REIDSVILLE, NC 27320	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix C0315	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # 10A NCAC 13G .1002(a)	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	05/06/2021	LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____		LSC _____		LSC _____	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR <i>Keisha Banks</i>	DATE 05/25/21
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/21/2018		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <span style="float:right;"><input type="checkbox"/> YES <input type="checkbox"/> NO</span>		