

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>06/19/2024</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
C 000	Initial Comments  The Adult Care Licensure Section conducted an annual survey on 06/19/24.	C 000		
C 330	<p>10A NCAC 13G .1004(a) Medication Administration</p> <p>10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: Based on interviews, observations and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#1) who had orders for an alpha blocker, a beta blocker, a laxative and a supplement.</p> <p>The findings are:</p> <p>1. Review of Resident #1's FL-2 dated 12/01/23 revealed diagnoses included schizoaffective disorder and hypertension.</p> <p>a. Review of Resident #1's FL-2 dated 12/01/23 revealed there was an order for tamsulosin (an alpha blocker used to treat difficulty with urination) 0.4mg take one tablet daily.</p> <p>Review of Resident #1's physician order dated 03/04/24 revealed there was an order increase tamsulosin 0.4mg administration from daily to</p>	C 330		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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C 330	<p>Continued From page 1</p> <p>twice daily.</p> <p>Review of Resident #1's physician order dated 04/08/24 revealed there was an order decrease tamsulosin 0.4mg from twice daily to daily.</p> <p>Review of Resident #1's physician order dated 05/30/24 revealed there was an order to discontinue tamsulosin 0.4mg.</p> <p>Review of Resident #1's April 2024 medication administration record (MAR) revealed: -There was an entry for tamsulosin 0.4mg take one tablet twice daily that was discontinued on 04/08/24. -There was an entry for tamsulosin 0.4mg take one tablet daily scheduled for administration at 5:00pm. -Tamsulosin 0.4mg was administered as ordered.</p> <p>Review of Resident #1's May 2024 MAR revealed: -There was an entry for tamsulosin 0.4mg take one tablet daily scheduled for administration at 8:00am. -There was documentation tamsulosin 0.4mg was administered as ordered.</p> <p>Review of Resident #1's June 2024 MAR from 06/01/24 to 06/19/24 revealed: -There was an entry for tamsulosin 0.4mg take one tablet daily scheduled for administration at 5:00pm. -There was documentation tamsulosin 0.4mg take one tablet daily was administered daily after it was discontinued on 05/30/24.</p> <p>Observation of Resident #1's medications on hand on 06/19/24 at 3:44pm revealed: -There was a medication card for tamsulosin</p>	C 330		

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C 330	<p>Continued From page 2</p> <p>0.4mg with a dispensed date of 06/06/24. -There was a medication start date of 06/14/24 and there were 25 of 30 tablets available for administration.</p> <p>Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/19/24 at 4:37pm was unsuccessful.</p> <p>Telephone interview with the facility's contracted pharmacy on 06/19/24 at 4:42pm revealed: -Tamsulosin 0.4mg take one tablet daily was an active order on file with the pharmacy. -Tamsulosin 0.4mg was dispensed on 04/27/24 and 05/30/24 for a quantity of 30 tablets each which was a 30-day supply.</p> <p>Interview with Resident #1 on 06/19/24 at 5:45pm revealed he was not sure which of his medications was tamsulosin, but he thought he was administered all his scheduled medications.</p> <p>Interview with the Administrator on 06/19/24 at 5:00pm revealed: -She did not see the discontinued order for Resident #1's tamsulosin until 06/19/24. -She did not fax Resident #1's new medication orders dated 05/30/24 to Resident #1's PCP or the pharmacy because she did not see them until 06/19/24.</p> <p>Refer to interview with the Administrator on 06/19/24 at 5:01pm.</p> <p>b. Review of Resident #1's physician order dated 05/30/24 revealed there was an order for carvedilol 12.5mg take one tablet twice daily.</p> <p>Review of Resident #1's May 2024 MAR revealed:</p>	C 330		

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C 330	<p>Continued From page 3</p> <p>-There was an entry for carvedilol 12.5mg take one tablet twice daily scheduled for administration at 8:00am and 5:00pm. -There was documentation carvedilol 12.5mg was administered as ordered.</p> <p>Review of Resident #1's June 2024 MAR from 06/01/24 to 06/19/24 revealed: -There was an entry for carvedilol 12.5mg take one tablet twice daily scheduled for administration at 8:00am and 5:00pm. -There was documentation carvedilol 12.5mg take one tablet daily was administered twice daily from 06/01/24 at 8:00am to 06/18/24 at 8:00am.</p> <p>Observation of Resident #1's medications on hand on 06/19/24 at 3:44pm revealed there was no carvedilol 12.5mg available for administration.</p> <p>Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/19/24 at 4:37pm was unsuccessful.</p> <p>Telephone interview with the facility's contracted pharmacy on 06/19/24 at 4:42pm revealed: -Carvedilol 12.5mg take one tablet twice daily was an active order on file with the pharmacy. -Carvedilol 12.5mg was dispensed on 05/30/24 for a quantity of 31 tablets which was a 15-and-a-half-day supply. -There were no refills written on the 05/30/24 prescription for carvedilol. -The pharmacy did not dispense the remaining 29 tablets of carvedilol on the 60-tablet prescription because there were not enough tablets to fill the facility's current cycle fill of medications which started on 06/14/24. -The pharmacy dispensed the remaining 29 tablets on the 05/30/24 prescription of carvedilol on 06/19/24.</p>	C 330		

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C 330	<p>Continued From page 4</p> <p>Interview with Resident #1 on 06/19/24 at 5:45pm revealed he knew he was administered blood pressure medication, but he did not know what carvedilol was.</p> <p>Interview with the Administrator on 06/19/24 at 5:00pm revealed: -She did not know Resident #1 ran out of carvedilol for a few days until 06/19/24. -She documented carvedilol administration for Resident #1 on the MAR because she thought he was administered the medication.</p> <p>Refer to interview with the Administrator on 06/19/24 at 5:01pm.</p> <p>c. Review of Resident #1's physician's order dated 04/08/24 revealed there was an order for polyethylene glycol (a laxative used to treat constipation) 17g take 1 tablet twice daily.</p> <p>Review of Resident #1's April 2024 medication administration record (MAR) revealed: -There was an entry for polyethylene glycol 17g take 1 tablet twice daily in 8oz of liquid scheduled for administration at 8:00am and 8:00pm. -There was documentation polyethylene glycol 17g was administered as ordered.</p> <p>Review of Resident #1's May 2024 MAR revealed: -There was an entry for polyethylene glycol 17g take 1 tablet twice daily in 8oz of liquid scheduled for administration at 8:00am and 8:00pm. -There was documentation polyethylene glycol 17g was administered as ordered.</p> <p>Review of Resident #1's June 2024 MAR from 06/01/24 to 06/19/24 revealed:</p>	C 330		

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C 330	<p>Continued From page 5</p> <p>-There was an entry for polyethylene glycol 17g take 1 tablet twice daily in 8oz of liquid scheduled for administration at 8:00am and 8:00pm.</p> <p>-There was documentation polyethylene glycol 17g was administered as ordered.</p> <p>Observation of Resident #1's medications on hand on 06/19/24 at 4:24pm revealed there was a sealed, unopened bottle of polyethylene glycol 17g dated 04/08/24.</p> <p>Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/19/24 at 4:37pm was unsuccessful.</p> <p>Telephone interview with the facility's contracted pharmacy on 06/19/24 at 4:42pm revealed:</p> <p>-There was an active order on file for Resident #1 for polyethylene glycol 17g twice daily with 8oz of liquid.</p> <p>-Polyethylene glycol was dispensed on 04/08/24 when it was a new order and there were no other dispense dates.</p> <p>Interview with Resident #1 on 06/19/24 at 5:45pm revealed:</p> <p>-He had not taken polyethylene glycol in 2 or 3 months.</p> <p>-He did not have any issues with constipation.</p> <p>Interview with the Administrator on 06/19/24 at 5:00pm revealed Resident #1 refused polyethylene glycol.</p> <p>Refer to interview with the Administrator on 06/19/24 at 5:01pm.</p> <p>d. Review of Resident #1's FL-2 dated 12/01/23 revealed there was an order for folic acid (a supplement used to reduce the risk of heart</p>	C 330		

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C 330	<p>Continued From page 6</p> <p>disease) 1mg take one tablet daily.</p> <p>Review of Resident #1's April 2024 medication administration record (MAR) revealed: -There was an entry for folic acid 1mg take one tablet daily scheduled for administration at 8:00am. -Folic acid was administered as ordered.</p> <p>Review of Resident #1's May 2024 MAR revealed: -There was an entry for folic acid 1mg take one tablet daily scheduled for administration at 8:00am. -There was no documentation folic acid was administered as ordered and the entry was crossed out.</p> <p>Review of Resident #1's June 2024 MAR from 06/01/24 to 06/19/24 revealed: -There was no entry for folic acid 1mg take one tablet daily. -There was no documentation folic acid 1mg take one tablet daily was administered.</p> <p>Observation of Resident #1's medications on hand on 06/19/24 at 3:44pm revealed there was no folic acid 1mg available for administration.</p> <p>Attempted telephone interview with Resident #1's primary care provider (PCP) on 06/19/24 at 4:37pm was unsuccessful.</p> <p>Telephone interview with the facility's contracted pharmacy on 06/19/24 at 4:42pm revealed: -Folic acid 1mg one tablet daily was an active order on file with the pharmacy. -Folic acid 1mg was dispensed on 04/27/24 and 05/30/24 for a quantity of 30 tablets each which was a 30-day supply.</p>	C 330		

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C 330	<p>Continued From page 7</p> <p>Interview with Resident #1 on 06/19/24 at 5:45pm revealed he was not sure which of his medications was folic acid, but he thought he was administered all his scheduled medications.</p> <p>Interview with the Administrator on 06/19/24 at 5:00pm revealed: -The folic acid medication order entry was crossed out and not documented on Resident #1's May MAR. -She did not notice that folic acid was not on Resident #1's June MAR. -She thought the folic acid medication order entry was accidentally crossed out on Resident #1's May MAR. -The pharmacy told her Resident #1's folic acid order entry was not transferred over to the June MAR.</p> <p>Refer to interview with the Administrator on 06/19/24 at 5:01pm.</p> <p>Interview with the Administrator on 06/19/24 at 5:01pm revealed she administered Resident #1's medications and she was responsible to administer medications as ordered.</p>	C 330		