STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017037	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEVERLY RUCKER FAMILY CARE HOME #8	6878 NC HIGHWAY 150 REIDSVILLE, NC 27320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 07/29/25-07/31/25 with a telephone exit on 07/31/25.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2.1(9), family care homes shall have a capacity of two to six residents. For the purposes of this Rule, "capacity" means the maximum number of residents permitted to live in a licensed family care home in accordance with the North Carolina Building Code and the evacuation capability of each resident. (b) The total number of residents shall not exceed the number shown on the license. The license shall indicate the facility's capacity for ambulatory and non-ambulatory individuals permitted to live in the facility. For the purposes of this Rule, "ambulatory" means the individual is able to respond and evacuate from the facility without verbal or physical assistance from others in the event of an emergency. "Non-ambulatory" means the individual is not able to respond and evacuate from the facility without verbal or physical assistance from others in the event of an emergency. (c) A request for an increase in capacity by adding rooms, remodeling, or without building modifications shall be made to the county department of social services and submitted to the Division of Health Service Regulation Construction Section and shall include two copies of blueprints or floor plans. One plan shall show the existing building with the current use of rooms, and the second plan showing the addition, remodeling, or change in use of spaces, and	C 007		

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C 007	Continued From page 1 showing the use of every room. If new construction, the second plan shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed facilities increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire facility shall meet all current fire safety regulations required by city ordinances or county building inspectors. (e) The licensee or the licensee's designee shall notify the Division of Health Service Regulation Adult Care Licensure Section if the evacuation capabilities of the residents changes and the facility no longer complies with the facility's licensed capacity as listed on the facility's license, or of the addition of any non-resident who will be living within the facility. (f) If there is a temporary change in the capacity of the facility due to a resident's short term illness or condition that renders the resident temporarily non-ambulatory, such as end of life condition, the licensee or the licensee's designee shall immediately notify the Division of Health Service Regulation Construction Section upon the knowledge of the change in the resident's ambulatory status. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Division of	C 007		

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C 007	Continued From page 2	C 007		

Health Service Regulation (DHSR) that the resident's evacuation capabilities were different from the evacuation capabilities listed on the facility's license for 1 of 4 sampled residents who did not exit the facility during a fire drill.

The findings are:

Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 6 ambulatory residents.

Review of the facility's fire drill form dated 03/01/25 at 9:08am revealed:
-An unannounced fire drill was performed.
-The staff and the residents exited the facility.
-Other staff present was the Administrator.
-There was no documentation about how many residents were present.
-Evacuation time was 52 seconds.

Review of the facility's fire drill form dated 04/19/25 at 7:28pm revealed:
-An unannounced fire drill was performed.
-The staff and the residents exited the facility.
-Other staff present was the Administrator.
-There was no documentation about how many residents were present.
-Evacuation time was 49 seconds.

Review of the facility's fire drill form dated 05/06/25 at 2:44pm revealed:
-An unannounced fire drill was performed.
-The staff and the residents exited the facility.
-Other staff present was the Administrator.
-There was no documentation about how many residents were present.
-Evacuation time was 50 seconds.

Review of the facility's fire drill form dated

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C 007	Continued From page 3 07/07/25 at 10:14am revealed: -An unannounced fire drill was performed. -The staff and the residents exited the facility. -Other staff present was the Administrator. -There was no documentation about how many residents were present. -Evacuation time was 58 seconds. Observation of the facility on 07/29/25 from 3:42pm-3:46pm revealed: -There were 2 residents inside the facility. -One resident was outside in the smoking area. -The Supervisor-in-Charge (SIC) sounded an audible alarm from the facility's fire panel. -One resident, inside the facility, was seated on the couch in the living room. -A second resident who was in his room started to exit the facility. -The second resident stopped in front of the other resident on the couch but did not say anything to the resident. -The second resident went out the door in front of the resident who remained seated on the couch. -The resident on the couch did not exit the facility. Telephone interview with the Administrator on 07/29/25 at 6:20pm revealed: -All of the residents responded to the fire drills at the facility. -She knew the residents prompted one of the residents sometimes, but not always. -She had not had any concerns about the resident not responding to fire drills. -She did not know she needed to let the Construction section know if a resident did not respond to a smoke alarm without verbal prompting. Refer to Tag C0022 10A NCAC 13G .0302(b) Design and Construction.	C 007		

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C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) New construction, additions, alterations, modifications, and renovations to buildings shall meet the requirements of the North Carolina State Building Code: Residential Code, and the North Carolina State Building Code: Building Code, Licensed Residential Care Facilities Section at the time of construction, alteration, modifications, and renovations. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that the evacuation capabilities for 1 of 4 sampled residents (#1), who did not respond to a fire alarm were in accordance with the evacuation capability listed on the facility's current license. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 6 ambulatory residents. Review of the facility's fire drill form dated 03/01/25 at 9:08am revealed: -An unannounced fire drill was performed.	C 022		

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C 022	Continued From page 5 -The staff and the residents exited the facility. -Other staff present was the Administrator. -There was no documentation about how many residents were present. -Evacuation time was 52 seconds. Review of the facility's fire drill form dated 04/19/25 at 7:28pm revealed: -An unannounced fire drill was performed. -The staff and the residents exited the facility. -Other staff present was the Administrator. -There was no documentation about how many residents were present. -Evacuation time was 49 seconds. Review of the facility's fire drill form dated 05/06/25 at 2:44pm revealed: -An unannounced fire drill was performed. -The staff and the residents exited the facility. -Other staff present was the Administrator. -There was no documentation about how many residents were present. -Evacuation time was 50 seconds. Review of the facility's fire drill form dated 07/07/25 at 10:14am revealed: -An unannounced fire drill was performed. -The staff and the residents exited the facility. -Other staff present was the Administrator. -There was no documentation about how many residents were present. -Evacuation time was 58 seconds. Review of Resident #1's current FL2 dated 03/28/25 revealed: -Diagnoses included bipolar disorder, intellectual disability, chronic kidney disease, and constipation. -There was no documentation about the resident's orientation.	C 022		

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C 022	Continued From page 6 Review of Resident #1's Resident Register revealed an admission date of 08/17/20. Review of Resident #1's care plan dated 03/28/25 revealed: -He was forgetful and needed reminders. -He required extensive assistance from staff with bathing, dressing, grooming, and personal hygiene. Review of the Licensed Health Professional Support (LHPS) review dated 05/05/25 revealed Resident #1 was able to perform most transfers unassisted, but at times he would require hands-on assistance from staff when rising from a low-seated position. Observation of the facility on 07/29/25 from 3:42pm-3:46pm revealed: -The Supervisor-in-Charge (SIC) sounded an audible alarm from the facility's fire panel. -Resident #1 was seated on the couch in the living room. -A second resident, who was in his room, started to exit the facility. -The second resident stopped in front of Resident #1 but did not say anything to the resident. -The second resident went out the door in front of Resident #1, who remained seated on the couch. -Resident #1 did not exit the facility. Interview with Resident #1 on 07/29/25 at 3:50pm revealed: -He did not know what a fire drill was. -If there was a fire at the facility, he would throw water on it. -If he heard a smoke alarm, he would cut it off.	C 022		

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C 022	Continued From page 7 Interview with the second resident on 07/29/25 at 3:56pm revealed: -The Administrator told the SIC when to do fire drills. -Resident #1 always needed assistance during fire drills. -Residents told Resident #1 he needed to leave the facility. Interview with a third resident on 07/29/25 at 3:56pm revealed: -The SIC set the alarm off, and the residents' hollered fire. -The residents had to "drag" Resident #1 out of the facility. -The residents had to go and get Resident #1 physically. -The Administrator told the residents that if Resident #1 did not want to get out, "drag" him out. Interview with the SIC on 07/29/25 at 3:54pm revealed: -The other residents usually got Resident #1 to go with them outside during fire drills. -Resident #1 did not understand. -Resident #1 was forgetful. -He did a fire drill every Friday before he left the facility for the week. -If Resident #1 was in bed when he did the fire drill, the other residents would all go get Resident #1 up to go outside. Telephone interview with the LHPS nurse on 07/29/25 at 1:55pm revealed: -She did not think Resident #1 would know how to respond to a smoke detector being activated without the assistance of others. -Resident #1 did not have dementia, but he was forgetful.	C 022		

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C 022	Continued From page 8 -Resident #1 could also have mobility issues because he shuffled his feet when he walked. Telephone interview with Resident #1's family member on 07/31/25 at 8:28am revealed: -Resident #1 would need someone to tell him that he needed to exit the facility in the event of an emergency. -Resident #1 would freeze up and not know what to do. Telephone interview with the Administrator on 07/29/25 at 6:20pm revealed: -The staff did fire drills using a smoke detector that was kept at the sister facility. -The SIC would go to the sister facility to get the smoke detector, install a battery, go back to the facility, do the fire drill, and then return the smoke detector to the sister facility. -All of the residents responded to the fire drills at the facility. -She knew the other residents prompted Resident #1 sometimes, but not always. -When asked about Resident #1's orientation, she stated, "he normally did fairly well." -She had not had any concerns about Resident #1 not responding to fire drills. Telephone interview with Resident #1's primary care provider (PCP) on 07/29/25 at 3:04pm revealed Resident #1 probably would not know to exit the facility when he heard a smoke alarm; he would need assistance. _____ The facility failed to ensure the evacuation capabilities for 1 of 4 residents were consistent with the current license of 6 ambulatory residents, as evidenced by a resident residing in the facility who did not respond to a fire drill; the resident was diagnosed with an intellectual disability and	C 022		

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C 022	Continued From page 9 was forgetful and needed reminders (#1). This failure was detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 07/30/25. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON JULY 31, 2025.	C 022		
C 034	10A NCAC 13G .0302 (n) Design and Construction 10A NCAC 13G .0302 Design and Construction (n) The facility shall maintain and have available for review current sanitation and fire safety inspection reports. This Rule is not met as evidenced by: Based on interviews and record reviews facility failed to to have a current fire inspection available for review. The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 6 ambulatory residents. Review of the facility's county fire inspection revealed: -The fire inspection was dated 08/15/23. -The fire inspection was completed by a	C 034		

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C 034	Continued From page 10	C 034		

representative from the local health department.
-There was documentation that the fire safety conditions in the facility were unsatisfactory.
-There was no approved evacuation plan posted.
-The smoke detector/fire alarm system was not maintained with annual test reports provided.
-There was a smoke alarm chirping.

Review of an annual fire alarm inspection dated 05/22/24 revealed:
-The control panel was tested.
-The control panel was not connected to the fire department.
-The control panel power light was on.
-All the indicating lamp bulbs were in operating order.
-The trouble light was operable.
-The silence switch was operable.
-The panel had active zones.
-The panel had battery backup.

Telephone interview with a representative from the facility's fire inspection company on 07/30/25 at 8:19am revealed:
-They automatically inspected facilities based on the last inspection.
-She thought the Administrator had been told their company was not going to be able to reinspect the facility because it needed upgrades before the facility would pass inspection.

Telephone interview with a technician from the facility's fire inspection company on 07/30/25 at 10:49am revealed:
-The facility was not "up to code" for adult care homes.
-The facility should have strobe lights and smoke detectors in every room.
-When he inspected the facility in May 2024, he told the Administrator he would not do another

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C 034	Continued From page 11 inspection unless she brought the facility up to code. Telephone interview with a building inspector with the county health department on 07/30/25 at 8:34am revealed: -The facility had not been inspected since 2023. -On 08/09/23, the facility was inspected but was not approved because the smoke alarms were not working, and there was no evacuation plan posted in the facility. -It was important to have an annual fire inspection to meet licensure requirements and for the safety of the residents. -It was important for the smoke alarms to work to make sure the residents were notified promptly if there was a fire, so the residents could get out of the facility. Interview with the Administrator on 07/29/25 at 11:55am revealed she did not realize the fire inspection for the facility had not been completed since 2023. Telephone interview with the Administrator on 07/31/25 at 11:08am revealed: -She was responsible for scheduling annual inspections. -She knew she needed an annual fire inspection. -She thought someone had inspected the facility annually. -She did not know why she did not get an annual fire inspection for 2024. -She did not know the fire inspection for 2023 was not approved. -No one told her the fire inspection was not approved in 2023. -She thought she scheduled the fire inspection at the same time she scheduled the environmental health inspection, but did not recall when that	C 034		

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C 034	Continued From page 12 was.	C 034		
C 069	10A NCAC 13G .0312 (g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibiting wandering behavior, all outside entrance/exit doors shall have a continuously sounding device that is activated when the door is opened. The sound shall be audible throughout the facility. If a central system of remote sounding devices is provided, the control panel for the system shall be powered by the facility's electrical system, and be located in an area accessible to staff. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors that were accessible to a resident (#1), who had exited the facility on two occasions, had a continuously sounding device which was operational and audible throughout the facility to ensure the resident's safety. The findings are: Observation of the entrance/exit door to the	C 069		

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C 069	Continued From page 13 facility on 07/29/25 and 07/30/25 at various times between 8:00am-5:00pm revealed: -No alarm sounded when the door to the facility was opened and closed. -There was a large red alarm on the exit door. -There was a red sign indicating stop, emergency exit only. Observation of a second entrance/exit door to the facility on 07/30/25 at 1:14pm revealed the door was located off the kitchen, and no alarm sounded when the door was opened and closed; there was a large red alarm on the exit door. Observation of the Supervisor-in-Charge (SIC) on 07/30/25 at 1:14pm revealed she used a key to set the alarms on the doors; the door alarms emitted a loud audible alarm when opened. Review of Resident #1's current FL2 dated 03/28/25 revealed: -Diagnoses included bipolar, intellectual disability, chronic kidney disease, and constipation. -There was no documentation about the resident's orientation. Review of Resident #1's Resident Register revealed an admission date of 08/17/20. Review of Resident #1's care plan dated 03/28/25 revealed he was forgetful and needed reminders. Interview with the SIC on 07/30/25 at 12:46pm revealed: -The door alarms were turned on at 10:00pm and turned off at 6:00am. -There were no alarms on the door during the daytime. -None of the residents had walked away from the facility.	C 069		

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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 069	Continued From page 14 Interview with a resident on 07/30/25 at 1:00pm revealed: -Resident #1 could not go outside without supervision because he might walk off. -She recalled one day, last year, at about 2:00am, the door alarm went off and Resident #1 was out in the driveway of the facility. Interview with a second resident on 07/30/25 at 1:18pm revealed: -There were no door alarms on during the day, just at night. -Within the last month, he had to go get Resident #1 from around the back of the house. -He heard the door alarm go off during the night, and he saw Resident #1's door open, and the resident was not in his room. -He told the SIC Resident #1 was outside. Interview with Resident #1 on 07/30/25 at 1:08pm revealed: -He did not recall going outside the facility at 2:00am. -He liked to go outside. Interview with the SIC on 07/30/25 at 1:13pm revealed: -Resident #1 exited the facility around 2:30am, one day, he thought, last week. -The resident was in the driveway. -He thought he recalled a time when Resident #1 was outside beside the facility during the night, but he did not recall any of the details. Interview with another SIC on 07/30/25 at 2:08pm revealed: -She heard Resident #1 when he got up during the night to go to the bathroom, but the resident had never gone outside when she was working.	C 069		

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	FCL017037	A. BUILDING: _____ B. WING _____	07/31/2025

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C 069	Continued From page 15 -She kept an eye on Resident #1 when he was outside because he was at risk for falls. Telephone interview with the Licensed Health Professional Support (LHPS) nurse on 07/29/25 at 1:55pm revealed: -Resident #1 did not have dementia, but he was forgetful. -Resident #1 could have mobility issues because he shuffled his feet when he walked. Telephone interview with Resident #1's family member on 07/31/25 at 8:28am revealed: -Resident #1 was "childlike," he lived day by day. -Resident #1 had gotten mad when he lived at another facility and walked off; it was about 10 years ago. -She would want staff to know when Resident #1 was outside so the staff could watch Resident #1. -She could ask Resident #1 what he had to eat for a meal, and he would not remember. -She thought Resident #1's memory was getting worse. -When she was looking for placement for Resident #1, she had a hard time finding a facility to take him because his medical record showed he was a flight risk and had behaviors. -The Administrator at this facility was the only one who would take Resident #1. Telephone interview with the Administrator on 07/31/25 at 11:08am revealed: -Door alarms were turned on at night and turned off "first thing" in the morning. -The staff told her the alarms were turned off for the day between 7:30am-8:00am. -Resident #1 could go outside the facility without supervision. -Resident #1 would just sit in the smoking area or go to the sister facility.	C 069		

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C 069	Continued From page 16 -If Resident #1 exited the facility at 2:00am, she was not notified. -If she had known Resident #1 exited the facility at 2:00am, she would have made sure staff knew to watch him when he went outside. -If Resident #1 went outside at 2:00am, she would have purchased an alarm to be used during the day, so staff would know when the resident went outside. Telephone interview with Resident #1's primary care provider (PCP) on 07/29/25 at 3:04pm revealed Resident #1 was cognitively impaired. Attempted telephone interview with Resident #1's PCP on 07/30/25 at 8:09am was unsuccessful. _____ The facility failed to ensure that alarms on the exit doors were equipped with a continuously sounding device that was operational and audible throughout the facility between 6:00am-10:00pm. As a result, a resident (#1), who shuffled his feet when walking, was at risk of falling, and had exited the facility on two separate occasions at night, was able to access the door and was at risk of eloping when the alarm was not activated during the day. This failure resulted in a substantial risk of physical harm to the resident and constitutes a Type A2 Violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 07/30/25. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON JULY 31, 2025.	C 069		
C 078	10A NCAC 13G .0315 (a)(5) Housekeeping and Furnishings	C 078		

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C 078	Continued From page 17 10A NCAC 13G .0315 Housekeeping and Furnishings (a) A family care home shall: (5) be maintained in an uncluttered, clean, and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations and interviews, the facility failed to maintain an environment that was clean and free from hazards, as evidenced by an active infestation of bedbugs. The findings are: Review of information about bed bugs from the Centers for Disease Control (CDC) dated 04/26/24 revealed: -Bed bug infestations usually happened around where people slept. -Bed bugs hid during the day in the seams of mattresses, box springs, bed frames, headboards, dressers, in cracks, in crevices, and behind wallpaper. -Bed bugs could travel over 100 feet at night but tended to live within eight feet of where people slept. -Signs of infestations included bites on the face,	C 078		

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C 078	Continued From page 18	C 078		

neck, arms, and other parts of the body, exoskeletons and live bed bugs in the folds of mattresses and sheets, rusty colored blood spots on mattresses, sheets, and nearby furniture, and a sweet musty odor.
-Professional pest control companies should be contacted to treat bed bug infestations.

Observations of resident room #3 on 07/29/25 at 11:09am and 4:32pm revealed:
-There were numerous live bed bugs on the resident's bed sheet at the head of the bed.
-There were live bed bugs on the curtains and the lampshade.
-There was bed bug waste on the walls, ceilings, and windows.

Observation of resident room #3 on 07/30/25 at 12:21pm revealed:
-There were still live bed bugs on the curtains, walls, and lampshade.
-There were multiple live bed bugs on the wall by the resident's bed.
-There was a live bed bug on the second bed in the resident's room; he did not have a roommate.
-There was bed bug waste on the walls, ceilings, and windows.

Interview with the resident who resided in resident room #3, on 07/29/25 at 3:50pm revealed:
-He did not have any bed bugs in his room.
-He did not have any bed bug bites.
-When asked about the black markings on the walls, he shrugged his shoulders and did not answer.

Observation of resident room #4 on 07/29/25 at 11:41am revealed numerous nymphs (young bed bugs) and adult bed bugs on the resident's bed sheet at the head of the bed.

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C 078	Continued From page 19 Interview with the resident who resided in resident room #4 on 07/29/25 at 11:38am revealed: -He did not have any bed bugs in his room. -He did not know there were bed bugs in his bed. -He did not know when his sheets were washed. Telephone interview with the resident who resided in room #4's primary care provider's (PCP) nurse on 07/30/25 at 9:42am revealed: -Bed bugs in the facility put the residents at risk for skin irritation. -Bed bug bites that were left untreated could become infected. -The resident was treated for a rash on his navel on 06/23/25. -There was no documentation about the facility having bed bugs, but the rash could have been from bed bug bites. -The treatment for the rash would have been the same if they had known bed bugs were in the facility, but they would have told the staff to treat the residents' beds/rooms for bed bugs. Observation of resident room #2 on 07/29/25 at 11:15am and 4:29pm revealed: -There were numerous live bed bugs crawling on her bed sheets. -There were multiple small blood stains on the sheet at the headboard of the bed. -There was bed bug waste on the outlet by the resident's bed. -The wall, baseboard, and floor behind the resident's headboard were covered in bed bug waste. Interview with the resident who resided in resident room #2, on 07/29/25 at 11:42am revealed: -The blood stains on her bed sheets at her headboard were old.	C 078		

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C 078	Continued From page 20 -She did not know there were bed bugs in her bed. -She washed her sheets and hung them on the clothesline. -She did not recall when she last washed her sheets. -She did not know what the black marks were on the wall, floor, and outlet; she did not "look back there". Observation of resident room #1 on 07/30/25 at 8:15am revealed bed bug waste was on the walls, ceilings, and windows. Interview with the resident who resided in resident room #1, on 07/30/25 at 8:15am revealed: -He had not seen any bed bugs in his room for "a while". -He did not know what the black spots were on his wall; he had not noticed those. Interview with the Supervisor-in-Charge (SIC) on 07/30/25 at 4:22pm revealed: -He swept and mopped every Friday before he left the facility. -Sometimes he swept and mopped every day. -There was no vacuum cleaner at the facility or at the sister facility that he could use. -He had not noticed the corners and the walls in the residents' rooms had bed bug droppings on them. Telephone interview with the pest control technician from the facility's contracted pest control company on 07/30/25 at 8:11am revealed: -The pest control company was treating the facility once a month for regular pest and bug treatments. -The pest control company had been treating the facility for bed bugs since 08/12/24.	C 078		

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C 078	Continued From page 21 -He told the Administrator to wash and dry the residents' clothes and bedsheets on high heat between treatments. -The last time he treated the facility for bed bugs was two months ago. -He had given the Administrator a list of things to do at the facility between treatments. -He told the Administrator about four to five months ago to purchase and spray the facility with a [named] insecticide product between his treatments. -He let the Administrator know the named spray would not interfere with the treatments he did. -The spray should have been used every other day on upholstered furniture, mattresses, and any wooden furniture, and allowed to dry for two hours. -One step was to place the residents' clothes, curtains, and sheets in a dryer on high heat for 35 to 45 minutes every other day. -He instructed the Administrator to run everything in the dryer on high heat and then wash everything on high temperature setting and dry again on high heat. -The key to killing live bed bugs, nits (young bed bugs), larvae, and eggs was to place everything in the dryer first and then wash and dry again. -If the staff were washing the clothes and bedsheets without first drying them on high heat, the live bed bugs would come off in the wash, crawl out of the washer, and reinfest the facility. -He had noticed the facility did not have a dryer. -He was concerned the facility did not have a dryer because they needed a dryer to use for the clothes and bedsheets. -He recommended placing clothing, bedsheets, and curtains in the dryer every other day without washing to kill live bed bugs between washings. -A second step was to have the staff place items that could not be placed into the dryer into black	C 078		

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C 078	Continued From page 22	C 078		

trash bags and put the bags into a car that was sitting in direct sunlight on a hot day for six to eight hours.
-A third step was to purchase black plastic totes with locking lids or black trash bags for each resident to enclose their clothes in and place outside in the grass.
-His team would then place a chemical in each tote or bag to kill bed bugs and their eggs.
-The Administrator scheduled the treatment, but when he and his team arrived at the facility, the Administrator told him she did not have enough staff to put the residents' clothes into the bags, so they did not do the enclosed treatment on the clothes.
-He told the Administrator to purchase totes with locking lids so the residents could store their clothes once they had been treated, washed, and free of bed bugs, because the totes would keep the bed bugs out while they continued to treat the facility.
-The residents needed to stop hanging their clothes in the closets and storing them in the dressers.
-The Administrator did not purchase the totes, and the residents continued to store their clothes in the closets and dressers in the facility.
-The bed bugs could be in the furniture, walls, and curtain rods.
-There were mattress encasements on each bed.
-A fourth step was to vacuum the mattresses and furniture every other day by using a vacuum with an attachment that had a nylon stocking stretched over it.
-The nylon stocking would capture the live bed bugs, and they could not escape through the nylon; the stocking could be slid off the attachment, tied off, and tossed in the trash.
-He had put traps under the bed frames to catch the bed bugs when they crawled out of the wall;

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C 078	Continued From page 23	C 078		

the traps needed to be vacuumed.
-Vacuuming after using the spray and allowing the spray to dry was also effective when done together.
-If there were clusters of bugs and feces in the corners and seams of the walls near the ceilings, it was because a fumigation bomb was used.
-The Administrator was told not to use any kind of fumigating bombs because they counteracted the treatments he was providing.
-Using a fumigation bomb made the bed bugs move to higher places and spread to escape the fumes; he did not use them in treatments.
-He had seen bed bugs all over the facility, but they were the worst in the residents' rooms.
-He and two to three other technicians would treat the facility and the sister facility next door at the same time.
-The Administrator would take the residents to one of her other facilities for about four hours while they treated the facility.
-He was concerned the residents were going to another facility because they would spread bed bugs from one facility to the other.
-If the facility was not doing the preventative steps needed between his treatments, the bed bug infestation would never be resolved.

Interview with the Supervisor-in-Charge (SIC) on 07/29/25 at 11:35am revealed:
-The pest control company sprayed at the facility one day last week, but he did not recall the date
-He washed the residents' sheets on Monday, 07/28/25, and he did not see any bed bugs on the sheets.
-The facility was treated by staff with a bug bomb on Friday, 07/25/25.
-He sprayed the facility every day for bed bugs using a bed bug spray.
-He sprayed some days but not every day.

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C 078	Continued From page 24 -He last sprayed on Friday, 07/25/25. -The bed bug spray and the bed bug bombs were kept in the office. -When the facility was bombed last week, the residents went to the sister facility from 10:30am-1:30pm. -He washed all the sheets and hung them on the clothesline. -The facility did not have a dryer. -He had taken the laundry to the laundromat, but he did not recall when. -He did not hang clothes on the line; he always took the clothes to the laundromat. -He told the Administrator he had seen bed bugs since last week, but he did not recall the date. Observation of the bed bug spray on 07/30/25 at 4:44pm revealed: -A home pest control bed bug killer; it was not the [named] insecticide recommended by the pest control company. -There was no bed bug bomb available. Interview with the SIC on 07/30/25 at 4:22pm revealed: -He took all the residents' sheets and comforters to the laundromat on 07/29/25. -He did not know how long he had dried the clothes, but he had put $3.00 in each dryer. -He did not wash the residents' curtains. -The facility did not have a vacuum cleaner. Telephone interview with an environmental health specialist with the local health department on 07/31/25 at 10:15am revealed: -If the facility had bed bugs, it would be a sanitary issue for the residents who resided at the facility. -The facility had not been inspected since 2024. Interview with the Administrator on 07/29/25 at	C 078		

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C 078	Continued From page 25 11:55am revealed: -The staff took the clothes to the laundromat and put them on hot, hot heat. -Staff had notified her of 1-2 live bed bugs last week, 07/22/25. -She did not inspect the facility after being told about the bed bugs. -She had not done anything after being told about the bed bugs, because the pest control technician told her the bed bugs would crawl across the solution and then die. -The pest control company treated the facility based on a set schedule; she did not recall the last time the facility had been sprayed for bed bugs. -She knew staff members sprayed a [named] cleaner at the facility, but she was told not to use any other products because it would counteract the pest control company's chemicals. -She looked for bed bugs at the facility every two weeks or sooner if the staff told her. -She did not recall when she last did a bed bug inspection at the facility. Telephone interview with the Administrator on 07/31/25 at 11:08am revealed: -The pest management company representative told her the facility needed to be vacuumed. -She had not purchased a vacuum cleaner yet. -She did not recall when she was told she needed to vacuum the facility. -The pest control company told her not to "bomb" the facility because it would counteract his treatment. -She did not recall being told to purchase anything specific that could be sprayed in between his bed bug treatments. -She expected the SIC to clean the walls and ceilings when they cleaned, at least once a week. -The SIC should sweep and mop daily, and brush	C 078		

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C 078	Continued From page 26 around the top of the ceiling. -When the staff knew she was going to the facility, the facility was usually clean. -When she made a surprise visit, the facility was not clean. -The staff were supposed to take the curtains down to be washed. -The residents' clothing was bagged up and placed in the hot sun; she did not know when this was last done. -She had let families know the facility had bed bugs and was being treated. -She did not know the facility had been "bombed" until after the surveyor had talked with the SIC. -She did not know the SIC was spraying the facility with a bed bug spray. -She had done all she knew to do at the facility. _____ The facility failed to follow the recommendations from the pest control company to eradicate an active infestation of bed bugs and staff were taking measures that contraindicated the bed bug treatment recommended by the pest control company. This failure resulted in serious neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/29/25. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON JULY 31, 2025.	C 078		
C 107	10A NCAC 13G .0317 (f) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment	C 107		

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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 107	Continued From page 27 (f) Where there is live-in staff in a family care home, a hard-wired, electrically operated call system meeting the following requirements shall be provided: (1) the call system shall connect residents' bedrooms to the live-in staff bedroom; (2) when activated, the resident call shall activate a visual and audible signal in the live-in staff bedroom; (3) a resident call system activator shall be in residents' bedrooms at the resident's bed; (4) the resident call system activator shall be within reach of a resident lying on the bed; and (5) the resident call system activator shall be such that it can be activated with a single action and remain on until deactivated by staff at point of origin. This Rule is not met as evidenced by: Based on interview and observations, the facility failed to ensure the call system connecting each resident bedroom to the live-in-staff quarters was in working order. The findings are: Observation of the call bells in resident rooms #1 and #3 on 07/30/25 at 4:20pm revealed there was a string attached to a box on the wall labeled, pull the cord for help. Observation of the call bell system on 07/30/25 at 4:23pm revealed: -The call bell was tested in resident bedrooms #1 and #3. -The audible alarm did not activate either time for the 2 rooms tested. -The alarm light did not activate either time for the 2 rooms tested.	C 107		

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C 107	Continued From page 28 -The panel was in the kitchen. -There were 6 lights labeled for the resident rooms/beds. Interview with the Supervisor-in-Charge (SIC) on 07/30/25 at 4:22pm revealed: -If the residents needed him, they "just hollered". -He did not know if the call bell system worked or not. -He slept with his door open so he could hear the residents during the night. Interview with the resident who resided in room #1 on 07/30/25 at 4:20pm revealed: -He had never used the call bell, so he did not know if it worked or not. -If he needed staff, he would call for them. Telephone interview with the Administrator on 07/31/25 at 9:33am revealed: -The facility had call bells. -She did not know if the call bells worked or not. -She had not checked the call bells "in a while". -She did not recall the last time she checked the call bells.	C 107		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement.	C 131		

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C 131	Continued From page 29	C 131		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on interviews and record reviews, the facility failed to ensure that 1 of 2 sampled staff (A) who administered medications had successfully passed the written medication administration examination.

The findings are:

Review of Staff A's, medication aide (MA)/Supervisor-in-Charge (SIC) personnel record revealed:
-There was no hire date for Staff A.
-There was no signed job description for Staff A.
-There was documentation Staff A completed the 5 and 10-hour, state approved medication aide training on 02/14/23, 02/03/24, and 10/17/24.
-There was documentation Staff A completed the medication aide clinical skills checklist on 06/14/25.
-There was no documentation Staff A successfully passed the written medication administration examination.

Review of residents' medication administration records (MAR) for April 2025-July 2025 revealed Staff A documented he administered the residents' medications.

Interview with three residents on 07/29/25 from 8:05am-9:00am revealed Staff A, who worked at the sister facility, administered medications when he worked.

Interview with the Supervisor-in-Charge (SIC) on 07/29/25 at 8:10am revealed Staff A, who worked

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C 131	Continued From page 30 at the sister facility as the SIC, administered the residents' medications at this facility. Interview with the Staff A on 07/30/25 at 3:30pm revealed: -He worked at the sister facility as the SIC. -He administered the residents' medications at both facilities. Second interview with Staff A on 07/30/25 at 5:01pm revealed: -He worked at the facility and left for about 5-6 months, and resumed employment in June 2024. -A [named] nurse did his MA training; he thought it was "last year." -He had not taken the written medication administration exam. Telephone interview with the Nurse on 07/31/25 at 10:52am revealed: -He taught MAs in the classroom setting. -He gave the MAs he trained the MA clinical skills checklist the day the staff member was in the classroom. -He thought the MA clinical skills checklist was good for 60 days. -The MAs did enough to get the clinical skills checklist, but never took the test. -He could not recall what staff members had taken the medication aide class from the Administrator's facilities in the last 3 months. Telephone interview with the Administrator on 07/30/25 at 6:47pm revealed: -She thought Staff A started working in the spring of last year, 2024. -Staff A had not passed the written medication administration examination. -Staff A "just did" the clinical skills checklist. -Staff A started one time, was "validated", and	C 131		

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C 131	Continued From page 31 then stopped, and then got "validated" again in June 2025. -Staff A had not taken the medication administration examination because he did not have the required identification. Telephone interview with the Administrator on 07/31/25 at 11:08am revealed she had not observed Staff A do a medication pass "lately"; it has been about "about 5 months". [Refer to 10A NCAC 13G .1004(a) Medication Administration, 10A NCAC 13G .1004(i) Medication Administration] _____ The facility failed to ensure that staff who worked as a MA and administered medications to residents successfully passed the written MA examination before administering medications, which could result in medication errors. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 07/30/25. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON JULY 30, 2025.	C 131		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S.	C 145		

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C 145	Continued From page 32 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 1 of 3 sampled staff (A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR). The findings are: Review of Staff A's, medication aide (MA)/Supervisor-in-Charge (SIC) personnel record revealed: -There was no hire date for Staff A. -There was no signed job description for Staff A. -There was documentation that Staff A had a HCPR check completed on 03/09/24. -The social security number on the HCPR check, with Staff A's name handwritten, was not Staff A's social security number. Interview with Staff A on 07/30/25 at 5:01pm revealed he had worked at the facility, left for about 5-6 months, and then resumed employment at the facility in June 2024. Telephone interview with the Administrator on 07/31/25 at 9:33am revealed: -She completed a HCPR on Staff A. -She did not know why Staff A's name was written on an HCPR with a different social security number. -She knew she had a HCPR check for Staff A and would fax it to the surveyor. Request for Staff A's HCPR check results on 07/31/25 was not provided by the survey exit date.	C 145		

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C 148	10A NCAC 13G .0406 (a)(8) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 2 of 3 sampled staff (A and B) had an examination and screening for the presence of controlled substances completed upon hire. The findings are: 1. Review of Staff A's, medication aide (MA)/Supervisor-in-Charge (SIC) personnel record revealed: -There was no hire date for Staff A. -There was no signed job description for Staff A. -There was no documentation that Staff A had an examination and screening for the presence of controlled substances available. Interview with Staff A on 07/30/25 at 5:01pm revealed he had not had a drug screen completed upon hire. Telephone interview with the Administrator on 07/31/25 at 9:33am revealed: -She took the staff members to a local medical facility to obtain drug tests. -She thought Staff A had a drug test.	C 148		

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C 148	Continued From page 34 2. Review of Staff B's, Supervisor-in-Charge (SIC) personnel record revealed: -Staff B was hired as a SIC on 07/20/19. -There was no documentation that Staff B had an examination and screening for the presence of controlled substances available. Interview with Staff B on 07/30/25 at 1:49pm revealed: -He had not had a drug screen at this facility. -He had a drug screen at his previous facility. -He did not know he needed to have a drug screen. Telephone interview with the Administrator on 07/31/25 at 9:33am revealed: -She took the staff members to a local medical facility to obtain drug tests. -She thought Staff B had a drug test.	C 148		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601 Mangement and Other Staff (a) A family care home administrator who is approved in accordance with Rule .1501 of this Subchapter shall be responsible for the total operation and management of the facility to assure that all care and services are provided to maintain the health, safety, and welfare of the residents in accordance with all applicable local, state, and federal regulations and codes. The administrator shall also be responsible to the Division of Health Service Regulation and the county department of social services for complying with the rules of this Subchapter. The	C 185		

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C 185	Continued From page 35 co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the facility and for meeting and maintaining the rules of this Subchapter. The term "administrator" also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the total operation of the facility to meet and maintain rules for family care homes related to design and construction, outside entrance and exits, management, housekeeping and furnishings, health care, qualifications of medication staff, licensed health professional support, nutrition and food service, medication administration, residents rights, and other staff qualifications, all of which were the responsibility of the Administrator. The findings are: Telephone interview with the Licensed Health Professional Support (LHPS) nurse on 07/30/25 at 10:09am revealed: -She gave recommendations to the Administrator but could not make the Administrator do anything. -She expected the Administrator to follow through on her recommendations. -She was concerned that the overall lack of care	C 185		

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for the residents could lead to a negative outcome.
-She talked to the Administrator after each of her quarterly reviews.
-The LHPS reviews were usually repetitive, with the same issues "over and over".

Interview with the Administrator on 07/29/25 at 11:55am revealed:
-Staff had notified her of 1-2 live bed bugs last week, 07/22/25.
-She did not inspect the facility after being told about the bed bugs.
-She did not recall when she last did a bed bug inspection at the facility.

Telephone interview with the Administrator on 07/31/25 at 8:56am revealed:
-She visited the facility at least once a week, sometimes twice a week.
-She would go into the facility and sometimes spend fifteen minutes and sometimes longer like 35 to 40 minutes; it depended on what needed to be done.
-She did not go into the facility and spend hours at a time.
-She spoke to each resident when she went to the facility and asked them how things were.
-She checked the facility for cleanliness, looked at the medication administration records (MAR), checked the medications and sometimes she went into the residents' rooms to see if they were clean.
-She had not checked the call bells "in a while".
-She did not recall the last time she checked the call bells.
-She had not observed the MA do a medication pass "lately".
-She had not observed the MA do a medication pass in "about 5 months".

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C 185	Continued From page 37 Telephone interview with the Administrator on 07/31/25 at 1:24pm revealed: -She had observed meals when she was at the facility. -She observed meals about once a month and could not recall the last meal she had seen; it had been over two weeks. Noncompliance identified during the survey included: 1. Based on observations and interviews, the facility failed to maintain an environment that was clean and free from hazards, as evidenced by an active infestation of bedbugs.[Refer to Tag C 078, 10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings (Type A1 Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors that were accessible to a resident (#1), who had exited the facility on two occasions, had a continuously sounding device which was operational and audible throughout the facility to ensure the resident's safety. [Refer to Tag C 69, 10A NCAC 13G .0312(g) Outside Entrance and Exits (Type A2 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to refer 1 of 3 sampled residents (#1), who needed his toenails trimmed to a podiatrist. [Refer to Tag C 246, 10A NCAC 13G .0902(b) Health Care (Type A2 Violation)]. 4. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations made by the Licensed Health Professional Support (LHPS) nurse for 1 of 2 sampled residents (#2) related to a podiatry, eye,	C 185		

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C 185	Continued From page 38 and dental visit. [Refer to Tag C 255, 10A NCAC 13G .0903(d) Licensed Health Professional Support (Type A2 Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to ensure that the evacuation capabilities for 1 of 4 sampled residents (#1), who did not respond to a fire alarm were in accordance with the evacuation capability listed on the facility's current license. [Refer to Tag C 022 10A NCAC 13G .0302(b) Design and Construction (Type B Violation)]. 6. Based on interviews and record reviews, the facility failed to ensure that 1 of 2 sampled staff (A) who administered medications had successfully passed the written medication administration examination. [Refer to Tag C 131 10A NCAC 13G .0403(a) Qualifications of Medication Staff (Type B Violation)]. 7. Based on observations, interviews, and record reviews, the facility failed to have a 3-day supply of perishable and a 5-day supply of non-perishable food, based on the census and the menus in the facility, as evidenced by the limited food items stored at the facility. [Refer to Tag C 259, 10A NCAC 13G .0904(a)(3) Nutrition and Food Service (Type B Violation)]. 8. Based on observations and interviews, the facility failed to ensure each resident was treated with respect and dignity, as evidenced by the residents who resided in the facility had to go to the sister facility when the Supervisor-in-Charge (SIC) provided transportation for other facilities, and residents doing chores in the facility, including mowing grass and painting. [Refer to Tag C 311 10A NCAC 13G .0909 Resident Rights (Type B Violation)].	C 185		

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C 185	Continued From page 39 9. Based on observations, interviews, and record reviews, the facility failed to ensure the staff were always awake in the facility for the safety and supervision of a resident who was known to have exited the facility during the night (#1) and was unable to evacuate the facility in the event of an emergency. [Refer to Tag C 188, 10A NCAC 13G .0601(g) Management and Other Staff (Type B Violation)]. 10. Based on interviews and record reviews facility failed to have a current fire inspection available for review. [Refer to Tag C 034, 10A NCAC 13G .0302(n) Design and Construction (Standard Deficiency)]. 11. Based on interview and observations, the facility failed to ensure the call system connecting each resident bedroom to the live-in-staff quarters was in working order. [Refer to Tag C 107, 10A NCAC 13G ..0317(f) Building Service Equipment (Standard Deficiency)]. 12. Based on record reviews and interviews, the facility failed to ensure that 1 of 3 sampled staff (A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR). [Refer to Tag C 145, 10A NCAC 13G ..0406(a)(5) Other Staff Qualifications (Standard Deficiency)]. 13. Based on interviews and record reviews, the facility failed to ensure that 2 of 3 sampled staff (A and B) had an examination and screening for the presence of controlled substances completed upon hire. [Refer to Tag C 148, 10A NCAC 13G ..0406(a)(8) Other Staff Qualifications (Standard Deficiency)].	C 185		

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C 185	Continued From page 40 14. Based on observations, record reviews, and interviews, the facility failed to ensure the residents were served juice daily as recommended on the facility's menu and as recommended based on the U.S. Department of Agriculture Dietary Guidelines for Americans. [Refer to Tag C 273, 10A NCAC 13G .903(d)(3) Nutrition and Food Service (Standard Deficiency)]. 15. Based on observations, record reviews and interviews, the facility failed to substitute items on the lunch menu with items that had equal nutritional value and did not document each item substituted and served to the residents. [Refer to Tag C 266, 10A NCAC 13G .0904(c)(3) Nutrition And Food Service (Standard Deficiency)]. 16. Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 3 sampled residents (#1) regarding an order for a medication used to treat constipation. [Refer to Tag C 315, 10A NCAC 13G .1002(a) Medication Order. (Standard Deficiency)]. 17. Based on observations, interviews and record reviews, the facility failed to ensure medications were documented immediately after administration for 3 of 3 sampled residents. [Refer to Tag C 341, 10A NCAC 13G .1004(i) Medication Administration (Standard Deficiency)]. 18. Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that the resident's evacuation capabilities were different from the evacuation capabilities listed on the facility's license for 1 of 4 sampled residents who did not exit the facility during a fire drill.	C 185		

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BEVERLY RUCKER FAMILY CARE HOME #8	6878 NC HIGHWAY 150 REIDSVILLE, NC 27320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 185	Continued From page 41 [Refer to Tag C 007, 10A NCAC 13G .0206 Capacity (Standard Deficiency)]. _____ The Administrator failed to ensure the overall management and operation of the facility were conducted in a manner that provided the necessary services to maintain the physical and mental well-being of the residents. This was evidenced by the failure to comply with regulations governing adult care homes, which were the responsibility of the Administrator, including not arranging toenail care for a diabetic resident to prevent injury; not following the recommendations from the pest control company as evidenced by a bed bug infestation; not ensuring a door alarm and awake staff were in place for a cognitively impaired resident who had exited the facility at night; and not maintaining an adequate food supply for the residents. Additionally, the Administrator did not protect the residents' rights by requiring the residents to go to the sister facility when the staff provided transportation for multiple facilities and residents doing chores in exchange for money and snacks. This failure of the Administrator resulted in serious neglect of the residents which constitutes a Type A1 Violation. _____ A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON JULY 30, 2025.	C 185		
C 188	10A NCAC 13G .0601 (g) Mangement And Other Staff 10A NCAC 13G .0601 Management And Other Staff (g) Additional staff shall be employed as needed for housekeeping and the supervision and care of	C 188		

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C 188	Continued From page 42 the residents in accordance with the rules of this Subchapter. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the staff were always awake in the facility for the safety and supervision of a resident who was known to have exited the facility during the night (#1) and was unable to evacuate the facility in the event of an emergency. The findings are: Review of the facility's current license, effective 01/01/25, revealed the facility was licensed for 6 ambulatory residents. Review of Resident #1's current FL2 dated 03/28/25 revealed: -Diagnoses included bipolar, intellectual disability, chronic kidney disease, and constipation. -There was no documentation about the resident's orientation. Review of Resident #1's Resident Register revealed an admission date of 08/17/20. Review of Resident #1's care plan dated 03/28/25 revealed: -He was forgetful and needed reminders. -He required extensive assistance from staff with bathing, dressing, grooming, and personal	C 188		

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C 188	Continued From page 43 hygiene. Observation of Resident #1 on 07/29/25 and 07/30/25 at various times between 8:15am-5:00pm revealed he ambulated without assistance. Interview with the Supervisor-in-Charge (SIC) on 07/30/25 at 4:22pm revealed he slept with his door open so he could hear the residents during the night. Interview with a resident on 07/30/25 at 1:00pm revealed: -Resident #1 could not go outside without supervision because he might walk off. -She recalled one day, last year, at about 2:00am, the door alarm went off, and Resident #1 was out in the driveway of the facility. Interview with a second resident on 07/30/25 at 1:18pm revealed: -There were no door alarms on during the day, just at night. -Within the last month, he had to go get Resident #1 from around the back of the house. -He heard the door alarm go off during the night, and he saw Resident #1's door open, and the resident was not in his room. -He told the SIC Resident #1 was outside. Interview with Resident #1 on 07/30/25 at 1:08pm revealed: -He did not recall going outside the facility at 2:00am. -He liked to go outside. Second interview with the SIC on 07/30/25 at 1:13pm revealed: -Resident #1 exited the facility around 2:30am,	C 188		

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one day, he thought, last week.
-The resident was in the driveway.
-He thought he recalled a time when Resident #1 was outside beside the facility during the night, but he did not recall any of the details.

Interview with another SIC on 07/30/25 at 2:08pm revealed:
-She heard Resident #1 when he got up during the night to go to the bathroom, but the resident had never gone outside when she was working.
-She kept an eye on Resident #1 when he was outside because he was at risk for falls.

Telephone interview with Resident #1's family member on 07/31/25 at 8:28am revealed:
-Resident #1 was "childlike," he lived day by day.
-Resident #1 had gotten mad when he lived at another facility and walked off; it was about 10 years ago.
-She would want staff to know when Resident #1 was outside so the staff could watch Resident #1.
-She could ask Resident #1 what he had to eat for a meal, and he would not remember.
-She thought Resident #1's memory was getting worse.
-When she was looking for placement for Resident #1, she had a hard time finding a facility to take him because his medical record showed he was a flight risk and had behaviors.
-The Administrator at this facility was the only one who would take Resident #1.

Telephone interview with the Administrator on 07/31/25 at 11:08am revealed:
-If Resident #1 exited the facility at 2:00am, she was not notified.
-If she had known Resident #1 exited the facility at 2:00am, she would have made sure staff knew to watch him when he went outside.

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C 188	Continued From page 45 The facility failed to ensure there was awake staff at the facility to provide supervision to a resident (#1) who had exited the facility during the night and required supervision at all times for the safety of the resident, and who required assistance to exit the facility in the event of an emergency. The facility's failure was detrimental to the safety and welfare of the resident which constitutes a Type B Violation. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON JULY 31, 2025.	C 188		
C 246	10A NCAC 13G .0902(b) Health Care 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. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to refer 1 of 3 sampled residents (#1), who needed his toenails trimmed to a podiatrist. The findings are: Review of Resident #1's current FL2 dated 03/28/25 revealed diagnoses included diabetes, bipolar disorder, intellectual disability, chronic kidney disease, and constipation. Review of Resident #1's care plan dated 03/28/25 revealed: -He was forgetful and needed reminders.	C 246		

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C 246	Continued From page 46 -He required extensive assistance from staff with bathing, dressing, grooming, and personal hygiene. Review of Resident #1's podiatry after-visit summary date 11/25/24 revealed: -The resident had long, thick nails and calluses on the bottom of both feet. -The toenails were discolored, yellowish-brown and opaque, thick, brittle, and had separated from the nail bed. -The toenails were dystrophic (refers to nails that are abnormal in shape, color, texture, and/or growth); the affected toenails were on both feet. -The resident exhibited signs consistent with peripheral vascular disease affecting the lower extremity. -The resident was to return in 10 weeks, or if problems developed in the meantime or if the condition worsened, the staff were instructed to call the office for further instructions. Interview with Resident #1 on 07/29/25 at 11:04am revealed: -His toenails needed to be cut. -He could not cut his toenails. Observation of Resident #1's toenails on 07/29/25 at 11:04am revealed: -The first toenail on his left foot was thick, and the left edge of the toenail was jagged. -The second toenail on his left foot had curled completely over the end and was pushing into the skin on the bottom of the toe as well as the bottom side of the first toe. -The third toenail on his left foot had curled completely over the end and was pushing into the skin on the bottom of the toe. -The fourth toenail on his left foot had curled completely over the end and was pushing into the	C 246		

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skin on the bottom of the toe; part of the toenail had broken off, leaving it jagged.
-The fifth toenail on his left foot had curled completely over the end and was pushing into the skin on the bottom of the toe.
-The first toenail on his right foot was thick and exhibited a yellowish-brown discoloration, with the end of the toenail being black.
-The second and third toenails on his right foot extended past the end of the toe.
-The fourth and fifth toenails on his left foot had curled completely over the end and were pushing into the skin on the bottom of the toes.

Telephone interview with the Licensed Health Professional Support (LHPS) nurse on 07/29/25 at 1:55pm revealed:
-Long toenails could put pressure on Resident #1's toes and feet, and he could develop wounds.
-Resident #1 would have a difficult time healing if he developed any wounds because he had diabetes.
-People with diabetes were at risk for poor circulation in their feet, and that was a major concern because Resident #1 would not necessarily know if he had developed a wound.

Telephone interview with a representative from the podiatrist's office on 07/29/25 at 2:48pm revealed the last time Resident #1 was seen in their office was 11/25/24; the resident may have cancelled the follow-up appointment, but she was not able to see that information.

Telephone interview with Resident #1's primary care provider (PCP) on 07/29/25 at 3:04pm revealed:
-Resident #1 needed to be seen by a podiatrist for toenail care due to his diabetes.
-If Resident #1's toenails were long, the resident

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could injure his skin, causing a sore, and the sore could become infected.
-Long toenails also increased the risk of falls.
-It was hard to judge if Resident #1 had neuropathy in his feet due to the resident's cognition.

Interview with the Supervisor-in-Charge (SIC) on 07/29/25 at 5:02pm revealed:
-He assisted Resident #1 with a bath on Monday, Wednesday, and Friday.
-He washed Resident #1's feet during his bath.
-He noticed Resident #1's toenails were long.
-Resident #1 was supposed to go to see the podiatrist, but he did not know when.
-He could not cut Resident #1's toenails because the resident was diabetic.
-He did not wash the bottom of Resident #1's feet, so he did not know his toenails had grown over the ends of his toes.
-Resident #1 washed the bottom of his feet.
-He forgot to tell the Administrator that Resident #1's feet were looking "bad".

Telephone interview with Resident #1's family member on 07/31/25 at 8:28am revealed she did not think Resident #1 had the insight to tell anyone his toenails needed to be cut.

Telephone interview with a representative from Resident #1's podiatrist's office on 07/30/25 at 9:50am revealed it was important for a resident who was diabetic to have routine foot care with a professional because the resident was at an increased risk of injury and infection.

Telephone interview with the Administrator on 07/29/25 at 6:20pm revealed:
-She thought the SIC told her Resident #1's toenails needed to be cut one day last week.

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C 246	Continued From page 49 -Resident #1 went to a podiatrist. -She told the SIC she would make Resident #1 an appointment with the podiatrist. -She had not made an appointment with the podiatrist; she would call on 07/30/25. -She had not looked at Resident #1's toenails. -It bothered her that Resident #1's toenails had curled over the end of his toes. -It was not good for the resident's health or for his comfort to have long toenails. The facility failed to refer a resident with a diagnosis of diabetes, who required toenail trimming, to a podiatrist. As a result, the resident's toenails grew over the end of his toes and were pushing into the bottom of the toes, which increased the risk of injury, infection, and falls. This failure resulted in a substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation. The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 07/30/25. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON JULY 31, 2025.	C 246		
C 255	10A NCAC 13G .0903 (d) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (d) The facility shall follow-up and implement recommendations made by the licensed health professional including referral to the physician or appropriate health professional when indicated. The facility shall document follow-up on all recommendations made by the licensed health	C 255		

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C 255	Continued From page 50 professional. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations made by the Licensed Health Professional Support (LHPS) nurse for 1 of 2 sampled residents (#2) related to a podiatry, eye, and dental visit. The findings are: Review of Resident #2's current FL2 dated 05/28/25 revealed a diagnosis of type II diabetes. Review of Resident #2's Resident Register revealed an admission date of 12/29/17. Review of Resident #2's care plan dated 05/08/25 revealed he was independent with all of his care. a. Review of Resident #2's LHPS quarterly evaluation dated 05/05/25 revealed there was documentation that Resident #2 had poor dental hygiene, and the recommendation was to please be sure Resident #2 was seen for dental care. Telephone interview with the facility's contracted LHPS nurse on 07/30/25 at 10:00am revealed: -Resident #2 had "bad teeth". -She notified the Administrator that Resident #2 needed to see a dentist. -It was important for diabetic residents to have routine dental care. -A diabetic resident would also be at risk of becoming septic if there were an infection and it was not treated. -She expected the Administrator to follow up	C 255		

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C 255	Continued From page 51 when she made recommendations. -Diabetic residents need to see a dentist every 6 months. Interview with Resident #2 on 07/30/25 at 11:43am revealed: -He had not been to the dentist since he had lived at the facility. -He had not refused to go to the dentist, and no one had told him he had an appointment. -He had tooth pain before and took pain medication. -His teeth were not hurting right now. Telephone interview with the Administrator on 07/31/25 at 11:08am revealed: -Resident #2 had not been to the dentist. -She had a note to make an appointment. -She could not explain why Resident #2 had not been to the dentist after the LHPS recommended it. According to the National Institute of Diabetes and Digestive and Kidney Diseases, people with diabetes were more likely to have gum disease, cavities, and other problems with their teeth and gums. People with diabetes should see the dentist right away if they notice any signs or symptoms of mouth problems. Some mouth problems could make diabetes worse. The dentist was an important ally in keeping the mouth healthy and treating mouth problems before they became serious. Taking good care of teeth and gums, including getting regular cleanings and needed treatments, would help prevent these problems or stop them from getting worse. Keeping a person's mouth healthy would also make it easier to manage diabetes and prevent diabetes-related health problems, such as heart disease and kidney disease.	C 255		

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C 255	Continued From page 52 Refer to the telephone interview with the LHPS nurse on 07/30/25 at 10:09am. Refer to the telephone interview with the Administrator on 07/31/25 at 11:08am. b. Review of Resident #2's LHPS quarterly evaluation dated 05/05/25 revealed Resident #2 needed foot care for diabetes management. Telephone interview with the facility's contracted LHPS nurse on 07/30/25 at 10:00am revealed: -Residents who were diabetic were at high risk for poor circulation in their feet. -Neither staff nor residents should cut the toenails of a resident who was diabetic because the toenails could be cut too short or cause an injury. -If Resident #2 had diabetic neuropathy in his feet, he could have an injury that he did not feel, which could lead to an infection. -Diabetic residents should see a podiatrist every 6 months for foot care. Observation of Resident #2's toenails on 07/30/25 at 11:55am revealed: -All 5 toenails on the right foot were cut short. -The first toenail on the right foot was discolored, appearing to be yellowish-brown and thick. -The third toenail on the right foot had a very small amount of toenail visible. -The fourth toenail on the right foot had dried blood on the nailbed. -The bottom of the footbed had multiple calluses. -One of the calluses at the base of the first toe was cracked open. -All 5 toenails on the left foot were cut short. -The first, second, and fourth toenails on the right foot had dried blood on the nailbed. -The third toenail appeared to have been broken	C 255		

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as it was uneven.
-The fifth toenail on the right foot had a very small amount of toenail visible.

Interview with Resident #2 on 07/30/25 at 11:43am revealed:
-He cut his toenails.
-He had cut his toenails too short, which was why there was blood on some of his toes.
-He thought the crack under his first toe was "just from being hot".
-He tried to check his feet every day.

Telephone interview with a representative from the facility's contracted podiatrist's office at 9:50am revealed:
-It was important for a resident who was diabetic to have routine foot care with a professional because the resident was at an increased risk of injury and infection.
-A diabetic resident should not cut their toenails because they could cut the toenails too short.
-A diabetic resident's toenails were cut a certain way to prevent issues.
-A diabetic resident's toenails were not cut with regular toenail clippers, but with special tools in the podiatrist's office.

Telephone interview with the Administrator on 07/31/25 at 11:08am revealed:
-If the LHPS nurse told her a resident's toenails needed to be trimmed, she tried to follow up on it.
-Resident #2 had not been to a podiatrist because he said he did not need to go because he could cut his toenails.
-She did not know Resident #2 should not cut his toenails since he was diabetic.

According to the American Diabetic Association, diabetes could cause nerve damage. Lost

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BEVERLY RUCKER FAMILY CARE HOME #8	6878 NC HIGHWAY 150 REIDSVILLE, NC 27320

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sensitivity in the feet could make it difficult to know if a person with diabetes was hurt or injured, and even the smallest cuts and scrapes could become difficult to heal. Calluses occurred more often and built up faster on the feet of people with diabetes. Calluses, if not trimmed, got very thick, broke down, and turned into ulcers (open sores).

Refer to the telephone interview with the LHPS nurse on 07/30/25 at 10:09am.

Refer to the telephone interview with the Administrator on 07/31/25 at 11:08am.

c. Review of Resident #2's LHPS quarterly evaluation dated 05/05/25 revealed there was documentation that Resident #2 needed an annual eye examination.

Interview with Resident #2 on 07/30/25 at 11:43am revealed:
-He did not recall the last time he went to the eye doctor; it had been a while.
-He would like to go to the eye doctor to make sure everything was okay with his vision.
-He had a lazy eye.
-He had worn glasses since he was young.

Telephone interview with a representative from Resident #2's eye doctor's office on 07/31/25 at 9:28am revealed:
-Resident #2 was last seen on 12/13/23.
-Resident #2 was to return in one year.
-Resident #2 had cataracts.

Telephone interview with the LHPS nurse on 07/30/25 at 10:09am revealed:
-If Resident #2's finger stick blood sugar (FSBS) was "off," it could affect the resident's eyes.

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C 255	Continued From page 55 -Resident #2 was at risk for diabetic neuropathy in the eyes and glaucoma. -Resident #2 should be seen by an eye doctor annually. Review of Resident #2's FSBS log for 06/01/25-07/29/25 revealed FSBS values ranged from 107-287. Review of Resident #2's laboratory values dated 03/14/24 revealed a hemoglobin A1C (HbA1C) value of 7.7. The hemoglobin A1C test tells the average level of blood sugar over the past 2 to 3 months. (According to the American Diabetic Association, a HbgA1C value less than 7.0 is a goal for diabetic residents, with the normal range for HbA1C being 4 to 5.9). Telephone interview with the Administrator on 07/31/25 at 11:08am revealed Resident #2 had been to the eye doctor to get glasses, but she did not recall when it was. According to the American Diabetes Association, people with diabetes were at risk for diabetes-related eye diseases such as diabetic retinopathy, macular edema, glaucoma, and cataracts. Diabetes was the leading cause of new cases of blindness in adults aged 18-64 years. Diabetic retinopathy was the most common diabetic eye disease and a leading cause of blindness in American adults. In early stages, diabetic retinopathy may not have any obvious signs or symptoms, but finding it early could help protect vision, making an annual dilated eye exam essential for those living with diabetes. People with diabetes should have an annual dilated and comprehensive eye exam. Refer to the telephone interview with the LHPS	C 255		

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C 255	Continued From page 56 nurse on 07/30/25 at 10:09am. Refer to the telephone interview with the Administrator on 07/31/25 at 11:08am. _____ Telephone interview with the LHPS nurse on 07/30/25 at 10:09am revealed: -She gave recommendations to the administrator, but could not make the Administrator do anything. -She expected the Administrator to follow through on her recommendations. -She was concerned that the overall lack of care for the resident could lead to a negative outcome. -She talked to the Administrator after each of her quarterly reviews. -The LHPS reviews were usually repetitive, with the same issues "over and over". Telephone interview with the Administrator on 07/31/25 at 11:08am revealed: -She was responsible for reviewing the LHPS assessments for recommendation. -The LHPS nurse gave her the completed LHPS form with the recommendations, and the LHPS nurse reviewed it with her as well. _____ The facility failed to implement the LHPS nurse's recommendations for Resident #2 to see a podiatrist, dentist, and eye doctor. This resulted in the resident having toenails cut so short that bleeding occurred, which put the resident at risk for infections, and he had not had an eye exam since 2023, placing him at risk for diabetes-related eye disease not being treated in a timely manner. This failure resulted in a substantial risk for physical harm to the resident and constitutes a Type A2 Violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on	C 255		

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C 255	Continued From page 57 07/30/25. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON JULY 31, 2025.	C 255		
C 259	10A NCAC 13G .0904(a)(3) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (3) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule, for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to have a 3-day supply of perishable and a 5-day supply of non-perishable food, based on the census and the menus in the facility, as evidenced by the	C 259		

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C 259	Continued From page 58 limited food items stored at the facility. The findings are: Interview with the Supervisor-in-Charge (SIC) on 07/29/25 at 8:05am revealed there were 4 residents residing in the facility. Observation of the refrigerator on 07/29/25 at 8:18am revealed: -There were 9 eggs. -There was a pitcher of milk. -There was a jug of water. -There were 5 loaves of bread. -There was a shelf and a drawer that contained food that was identified as belonging to the staff. Observation of the freezer on 07/29/25 at 8:19am revealed there was one frozen pizza. Observations of the cabinet in the facility on 07/29/25 at 5:12pm revealed: -There was a container labeled as pancakes; there was one cup of pancake mix in the container. -There was a container of oatmeal; there were 2 cups of oatmeal in the container. -There was a container labeled as grits; there were eight cups of dry grits in the container. -There was no other non-perishable food in the facility. Review of the facility's breakfast menu for one week revealed: -On Monday, 1/2 cup of orange juice, ¾ cup of grits, 1 slice of toast, 1 sausage patty, and 1 cup of milk, water, and coffee were to be served. -On Tuesday, 1/2 cup of apple juice, ¾ cup of dry cereal, 2 slices of bacon, 1 slice of toast, and 1 cup of milk, water, and coffee were to be served.	C 259		

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C 259	Continued From page 59 -On Wednesday, 1/2 cup of orange juice, 1 scrambled egg on toast, ¾ cup of grits, and 1 cup of milk, water, and coffee were to be served. -On Thursday, 1/2 cup of tomato juice, ¾ cup of oatmeal, 1 sausage patty on a biscuit, and 1 cup of milk, water, and coffee were to be served. -On Friday, 1/2 cup of orange juice, 1 pancake with syrup, 1 slice of toast, 2 slices of bacon, and 1 cup of milk, water, and coffee were to be served. -On Saturday, 1/2 cup of apple juice, 1 scrambled egg, 1 slice of toast, ¾ cup of oatmeal, and 1 cup of milk, water, and coffee were to be served. -On Sunday, 1/2 cup of tomato juice, 1 fried egg, 2 rolls, 2 slices of bacon, and 1 cup of milk, water, and coffee were to be served. Review of the facility's lunch menu for one week revealed: On Monday, 1 ounce of turkey, 1 ounce of American cheese, 2 slices of bread, ½ cup of pineapple, 1 ounce of potato chips, ½ cup of steamed cabbage, and 1 cup of a beverage and water were to be served. -On Tuesday, 1/3 cup of chicken salad, 2 slices of white bread, ½ cup of carrots, 1 ounce of popcorn, 2 cookies, and 1 cup of a beverage and water were to be served. On Wednesday, 1 ounce of bologna, 1 ounce of American cheese, 2 slices of bread, ½ cup of lima beans, ½ cup of applesauce, and 1 cup of a beverage and water were to be served. -On Thursday, 1 hot dog, 1 hot dog bun, 1 ounce of corn chips, ½ cup of corn, and 1 cup of a beverage and water were to be served. -On Friday, 1 ounce of luncheon meat, 1 ounce of cheese, 2 slices of bread, 8 tater tots, ½ cup of green beans, ½ cup of mixed fruit, and 1 cup of a beverage and water were to be served. -On Saturday, 2 ounces of meat and 1 cup of	C 259		

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beans to make chili beans, 1 piece of corn on the cob, ½ cup of pears, 2 squares of cornbread, and 1 cup of a beverage and water were to be served.
-On Sunday, 2 ounces of sliced ham, ½ baked potato, 2 slices of bread, ½ cup of spinach, ½ cup of applesauce, and 1 cup of a beverage and water were to be served.

Review of the facility's dinner menu for one week revealed:
-On Monday, spaghetti with 1 cup of sauce and 2 ounces of meat, ½ cup of green beans, 1 slice of garlic bread, ½ cup of Jello, and 1 cup of milk, and water were to be served..
-On Tuesday, a 2-ounce charcoal beef patty with gravy, ½ cup of white rice, ½ cup of mixed vegetables, 1 slice of white toast, 1 cup of a beverage, 1 cup of milk, and water were to be served.
-On Wednesday, 2 ounces of meat loaf, ½ cup of potato salad, ½ cup of collard greens, 1 slice of white bread, ½ cup of peaches, 1 cup of a beverage, 1 cup of milk, and water were to be served.
-On Thursday, Salisbury steak with gravy, ½ cup of creamed potatoes, ½ cup of buttered cauliflower, 1 slice of white bread, 2 cookies, 1 cup of a beverage, 1 cup of milk, and water were to be served.
-On Friday, lasagna, 1 cup of sauce with 2 ounces of meat, ½ cup of spinach, 1 slice of garlic bread, ½ cup of peaches, 1 cup of a beverage, 1 cup of milk, and water were to be served.
-On Saturday, 2 ounces of breaded fish, 8 french fries, 3 hush puppies, ½ cup of squash, ½ cup of pineapple chunks, 1 cup of a beverage, 1 cup of milk, and water were to be served.
-On Sunday, 1/2 cup of beans, 2 hot dogs, ½ cup buttered broccoli, 1 slice of corn bread, ½ cup of

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C 259	Continued From page 61 pears, 1 cup of a beverage, 1 cup of milk, and water were to be served. Interview with a resident on 07/30/25 at 11:43am revealed: -He was served a boiled egg and oatmeal today. -He did not recall when he was last served breakfast meat. Interview with the Supervisor-in-Charge (SIC) on 07/30/25 at 12:46pm revealed: -The residents had pancakes, coffee, and water for breakfast on 07/29/25. -The residents had a boiled egg, oatmeal, water, milk, and coffee on 07/30/25. -The residents only ate breakfast at this facility; lunch and dinner were served at the sister facility. -He thought he last served breakfast meat on Monday, 07/28/25. -He thought he told the MA he needed breakfast meat, but he was not sure. Telephone interview with the Administrator on 07/31/25 at 9:33am and 11:08am revealed: -The facility received breakfast foods, including eggs and bread, weekly. -All other foods were stored at the sister facility because that was where the lunch and dinner meals were served. -She purchased food weekly for the facility and the sister facility. -She purchased bulk food and filled containers at the facility weekly. -If the facility was out of something, the containers could be filled up more often. -No one had ever told her she needed a 5-day supply of food at the facility. -Food had always been kept at the sister facility for both facilities.	C 259		

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C 259	Continued From page 62 The facility failed to maintain a 3-day supply of perishable and a 5-day supply of non-perishable food available at the facility for the residents' meals based on the menu, putting the residents at risk of not having food available to eat in the event of a disaster at the facility where the food was stored. This failure was detrimental to the residents' health, safety, and welfare and constitutes a Type B Violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 07/30/25. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON JULY 31, 2025.	C 259		
C 266	10A NCAC 13G .0904 (c)(3) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to substitute items on the lunch menu with items that had equal nutritional value and did not document each item	C 266		

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C 266	Continued From page 63 substituted and served to the residents. The findings are: Observation of the lunch meal in the sister facility located next door on 07/29/25 from 1:55pm to 12:12pm revealed: -There were five residents; three residents from the facility and two residents from the sister facility. -There was one resident out of the facility. -The residents were served various sized portions of salmon with rice, one cup of French fries, a slice of white bread, a cup and a half portion of lentil beans, 1 cup of water and 1 cup of milk. Review of the facility's lunch menu for 07/29/25 at 9:26am revealed: -The weekly menu was posted on a bulletin board in the kitchen. -The menu for the lunch meal on Tuesday 07/29/25, was a sandwich with a quarter cup of tuna fish salad and two slices of white bread, a half cup of stir-fried vegetables, five each onion rings, a half cup of applesauce, and water. Review of the facility's substitution log on 07/29/25 at 9:27am and 3:52pm revealed: -The substitution log was posted on a bulletin board in the kitchen. -The headers on the columns were date, item on the menu and item served. -On 07/29/25 at 9:27am, tuna was documented as the item on the menu and salmon was documented as the item served; no other items were documented as substituted on the lunch menu. -At 3:52pm, there were no other substitutions documented for the lunch meal served on 07/29/25.	C 266		

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C 266	Continued From page 64 Review of the facility's substitution log on 07/30/25 at 8:07am revealed there were no other items documented as substitutions on the lunch meal served 07/29/25. Interview with a resident on 07/29/25 at 5:10pm revealed: -The meals were usually the same foods repeatedly, hot dogs or pizza. -They were served French fries a lot. -They were not served fruit very often. -He thought he was served fruit about three times a week. Telephone interview with the facility's Licensed Health Professional Support (LHPS) nurse on 07/29/25 at 2:35pm revealed: -The residents complained to her about the repetitive meals they were served. -They told her they got hot dogs or bologna every day. -She was concerned about the number of carbohydrates the residents who had diabetes were being served at meals. Interview with the medication aide (MA)/SIC on 07/29/25 at 8:15am revealed: -The residents from both facilities ate together at the facility next door. -There were usually seven residents at the lunch and dinner meals. -All the residents were on regular diets. -He was going to serve the residents salmon, rice, beans, milk and water for the lunch meal. Second interview with the MA on 07/29/25 at 12:16pm revealed: -He substituted the French fries for the vegetables on the lunch menu.	C 266		

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C 266	Continued From page 65 -The rice went with the salmon. -The bread was on the menu and the residents always wanted bread with their meals, so he just gave them a slice. -The Administrator told him to serve the beans; he did not know why. -He forgot to give the residents the applesauce. -He thought he had fruit he could have given to them. -If he did not have a food item on the menu, he called the Administrator. -He would tell her what was on the menu and what food he did not have to serve. -He would tell her what food he had at the facility, and she would tell him what to serve from what he had. -He documented the meal substitutions on the substitution sheet. -He did not realize there were no vegetables in the meal he served. -He did not realize he served four carbohydrates and no fruit or vegetables at the lunch meal. Telephone interview with the Administrator on 07/31/25 at 1:24pm revealed: -She made the decisions on what foods to substitute for meals. -She would tell the staff what to serve if they did not have a food item. -The MA would call her and tell her they did not have an item on the menu. -She would ask the MA what food they had at the facility. -She tried to make equal swaps and do a like item for a like item, for example a fish for fish or green for green. -She told the MA to substitute salmon for tuna fish at lunch on 07/29/25. -She did not recall the MA needing to substitute any other items.	C 266		

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C 266	Continued From page 66 -The MA did not call her about any other substitutions. -She had told the MA once that he could substitute the onion rings with French fries. -She did not approve the lentil beans and she did not know why he served them. -There were multiple canned vegetables and fruit in the food storage bins in the storage room. -She did not know why the MA did not prepare and serve them. -She would not have told him to swap dried beans for vegetables because the beans were a carbohydrate and not a vegetable. -If the MA had called her she would have told him what to serve; she would have told him to go get the fruit. -There were too many starchy carbohydrates served at the lunch meal. -Every time the MA substituted an item on the menu he was supposed to document it on the substitution sheet. -She saw the substitution sheet when she was at the facility on 07/29/25; the MA/SIC had documented the salmon substitution for the tuna fish salad. -She did not know about the other substitutions to the meal. -If she had seen the substitution sheet and the lunch meal she would have told the MA he needed to document everything. -She had observed meals when she was at the facility. -She observed meals about once a month and could not recall the last meal she had observed but, it had been over two weeks.	C 266		
C 273	10A NCAC 13G .0904(d)(3) Nutrition and Food Service	C 273		

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C 273	Continued From page 67 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary Guidelines for Americans 2020-2025, which are hereby incorporated by reference, including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf, at no cost. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents were served juice daily as recommended on the facility's menu and as recommended based on the U.S. Department of Agriculture Dietary Guidelines for Americans. The findings are: Review of the U.S. Department of Agriculture Dietary Guidelines for Americans dated 2020-2025 revealed: -Adults aged 19-59 and 60+ should consume a minimum of 1 1/2 cups of fruit daily for a 1600-calorie diet and up to 2 cups for higher caloric diets. -The fruit food group included whole fruits and	C 273		

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C 273	Continued From page 68 100% fruit juice. -Whole fruits included fresh, canned, frozen, and dried forms. -Whole fruits could be eaten in various forms, such as cut, sliced, diced, or cubed. -At least half of the recommended amount of fruit should come from whole fruit, rather than 100% juice. -When juices were consumed, they should be 100% juice and always pasteurized or 100% juice diluted with water (without added sugars). Observation of the refrigerator on 07/29/25 at 8:18am revealed: -There were 9 eggs. -There was a pitcher of milk. -There was a jug of water. -There were 5 loaves of bread. -There was no juice in the refrigerator. Observation of the freezer on 07/29/25 at 8:19am revealed: -There was one frozen pizza. -There was no fruit or juice in the freezer. Observations of the cabinet in the facility on 07/29/25 at 5:12pm revealed: -There was a container labeled as pancakes; there was one cup of pancake mix in the container. -There was a container of oatmeal; there were 2 cups of oatmeal in the container. -There was a container labeled as grits; there were eight cups of dry grits in the container. -There was no canned fruits or juices at the facility. Review of the facility's breakfast menu for one week revealed: -On Monday, 1/2 cup of orange juice, ¾ cup of	C 273		

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grits, 1 slice of toast, 1 sausage patty, and 1 cup of milk, water, and coffee were to be served.
-On Tuesday, 1/2 cup of apple juice, ¾ cup of dry cereal, 2 slices of bacon, 1 slice of toast, and 1 cup of milk, water, and coffee were to be served.
-On Wednesday, 1/2 cup of orange juice, 1 scrambled egg on toast, ¾ cup of grits, and 1 cup of milk, water, and coffee were to be served.
-On Thursday, 1/2 cup of tomato juice, ¾ cup of oatmeal, 1 sausage patty on a biscuit, and 1 cup of milk, water, and coffee were to be served.
-On Friday, 1/2 cup of orange juice, 1 pancake with syrup, 1 slice of toast, 2 slices of bacon, and 1 cup of milk, water, and coffee were to be served.
-On Saturday, 1/2 cup of apple juice, 1 scrambled egg, 1 slice of toast, ¾ cup of oatmeal, and 1 cup of milk, water, and coffee were to be served.
-On Sunday, 1/2 cup of tomato juice, 1 fried egg, 2 rolls, 2 slices of bacon, and 1 cup of milk, water, and coffee were to be served.
-Three cups of juice were to be served weekly.

Interview with a resident on 07/29/25 at 11:04am revealed he was not served juice at breakfast; he liked juice.

Interview with a second resident on 07/30/25 at 11:43am revealed:
-He was not served juice to drink for breakfast.
-He liked juice and would drink juice if it was provided.
-He only had coffee to drink with his breakfast every day.

Interview with the Supervisor-in-Charge (SIC) on 07/30/25 at 4:22pm revealed he gave the residents juice to drink when he had it; he did not recall when there was juice at the facility.

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C 273	Continued From page 70 Telephone interview with the Administrator on 07/31/25 at 9:33am and 11:08am revealed: -The staff member had probably used all the juice and had not let her know because they knew she would be bringing some in. -Whenever the facility was out of juice, the SIC should go to the sister facility to get juice and bring the juice back to the facility. -No one had told her the residents did not have juice for their breakfast meal on 07/29/25 and 07/30/25.	C 273		
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 each resident was treated with respect and dignity, as evidenced by the residents who resided in the facility had to go to the sister facility when the Supervisor-in-Charge (SIC) provided transportation for other facilities, and residents doing chores in the facility, including mowing grass and painting. The findings are: 1. Interview with the SIC on 07/29/25 at 8:10am and 8:31am revealed: -He was late leaving the facility to take a resident to an appointment today, 07/29/25, from another facility.	C 311		

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-He did not leave the residents in the facility when he provided transportation.
-The residents went to the sister facility next door.
-He did not do transportation every day.

Interview with a resident on 07/29/25 at 10:58am revealed:
-She had to go to the sister facility every day when the SIC did transportation.
-Some days she had to go to the sister facility early, and some days it was later.
-She had to stay at the sister facility as late as 3:00pm.
-She did not like to go to the sister facility because it was hot inside.
-She wished she could go to her room and sleep when she wanted to, but could not when the SIC was not at the facility.

Interview with a second resident on 07/29/25 at 11:15pm revealed;
-When the SIC did transportation, he went to the sister facility next door.
-If the SIC only had 1-2 appointments, he was usually back to the facility "around lunch time."
-The latest he recalled being at the sister facility was 3:00pm-4:00pm.
-He wished he did not have to go to the sister facility, and he could stay here, at his facility, but he had to do what he was told.

Interview with the second resident on 07/30/25 at 11:43am revealed:
-He had been at the sister facility today, 07/30/25, for about an hour because the SIC had to go somewhere.
-The other residents rode with the SIC wherever he went.

Interview with the SIC on 07/29/25 at 11:35am

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revealed:
-He did transportation for the Administrator's multiple facilities, 2-3 days per week.
-He could not say how long he had been gone from the facility because it depended on the resident's appointment.
-The earliest he recalled leaving for an appointment was around 8:00am.
-The latest he recalled returning to the facility was around 2:00pm.
-Two residents usually stayed at the sister facility.

Interview with the medication aide (MA)/SIC from the sister facility on 07/30/25 at 12:09pm revealed:
-The Administrator usually called him to let him know when the residents from the sister facility would be coming to his facility, while the other SIC provided transportation.
-The residents usually stayed at the sister facility at least two days per week.
-The other SIC usually returned around 3:00pm.
-There were times when the residents would sleep on the couch or in an empty bed while at the sister facility.

Interview with the Administrator on 07/29/25 at 12:38pm revealed:
-The SIC did transportation 2-3 days per week.
-The residents either went with the SIC or stayed at the sister facility.
-Two named residents did not like to go with the SIC when he did transportation, so they usually stayed at the facility.
-No one had told her the residents did not like to stay at the sister facility.

2. Interview with the SIC on 07/29/25 at 8:10am revealed:
-A [named] resident was working at one of the

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C 311	Continued From page 73 Administrator's other facilities. -He then stated that the resident was not helping the Administrator; he was not sure who the resident was working for today, 07/29/25. Interview with a resident on 07/30/25 at 11:43am revealed: -He worked for the Administrator. -The Administrator gave him a juice or a snack, anything she knew he liked, when he did things for her. -He filled containers of food for the Administrator once a week. -He refilled the pantry with trash bags and toilet paper when it was needed. -He hung clothes on the line. -He mowed the grass and did other yard work. -The Administrator gave him cash when he did the yard work. -Four named residents worked for the Administrator and were paid with snacks or cash. Interview with a second resident on 07/30/25 at 1:00pm revealed: -She washed dishes, swept, mopped, and cleaned the bathroom at the facility. -The SIC gave her money or a drink. -The medication aide (MA) gave her a cigarette to help at the sister facility. -She liked working. Interview with a third resident on 07/30/25 at 1:18pm revealed: -He mowed grass and painted at multiple facilities for the Administrator. -The Administrator paid him cash to work. -Sometimes the Administrator gave him cigarettes for work. -He liked to work and stay busy.	C 311		

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C 311	Continued From page 74 Interview with the SIC on 07/30/25 at 4:22pm revealed the residents volunteered to do things for him, and he would give them a soda or a snack. Telephone interviews with the Administrator on 07/31/25 at 9:33am and 11:08am revealed: -The residents did not work for her; they did it for the staff at the facility. -Two [named] residents cut the grass at the facility. -She gave extra money to the two [named] residents to go shopping. -She gave the residents cigarettes and juice when they volunteered to do things at the facility, but she was not paying the residents; she was rewarding them. -The residents wanted to do things. -The residents helped her with groceries; they filled containers up for her. -"I am not making them." -The residents did things at the facility to get extra snacks, cigarettes and such. -"This is how the residents get things they want." _____ The facility failed to ensure the residents were treated with dignity and respect, related to residents having to stay at the sister facility when the SIC provided transportation to appointments for multiple facilities, and residents being paid with cash or snacks to do work around the facility. The facility's failure was detrimental to the residents' safety and welfare and constitutes a Type B Violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 on 07/30/25. A SUMMARY SUSPENSION OF LICENSE WAS	C 311		

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C 311	Continued From page 75 ISSUED ON JULY 31, 2025.	C 311		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 3 sampled residents (#1) regarding an order for a medication used to treat constipation. The findings are: Review of Resident #1's current FL2 dated 03/28/25 revealed diagnoses included diabetes, chronic kidney disease, hypertension, constipation, and bipolar disorder. Review of Resident #1's current FL2 dated 03/28/25 revealed an order for miralax (a stool softener), administer one capful in 8 ounces of water once daily.	C 315		

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C 315	Continued From page 76 Review of Resident #1's signed physician's orders dated 03/28/25 revealed an order for miralax, administer one capful in 8 ounces of water once daily for constipation. Review of a physician's order sheet dated 03/28/25 revealed: -There was an order for miralax 17g 2 times daily as needed for constipation. -The order was signed by the primary care provider's (PCP) nurse practitioner. Review of Resident #1's May 2025 medication administration record (MAR) revealed: -There was an entry for miralax, administer one capful in 8 ounces of water twice daily as needed for constipation. -There was no documentation that miralax was administered from 05/01/25-05/31/25. Review of Resident #1's June 2025 MAR revealed: -There was an entry for miralax, administer one capful in 8 ounces of water twice daily as needed for constipation. -There was no documentation that miralax was administered from 06/01/25-06/30/25. Review of Resident #1's July 2025 MAR from 07/01/25-07/29/25 revealed: -There was an entry for miralax, administer one capful in 8 ounces of water twice daily as needed for constipation. -There was no documentation that miralax was administered from 07/01/25-07/29/25. Observation of Resident #1's medications on hand on 07/29/25 at 4:22pm revealed there was a bottle of miralax dispensed on 06/04/25 with the	C 315		

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directions to use twice daily as needed for constipation; the bottle was ½ full.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/30/25 at 9:15am revealed:
-The current order on file for Resident #1's miralax was dated 03/19/25.
-The pharmacy had not received the PCP's response to the pharmacy review for miralax to be administered daily.

Interview with Resident #1 on 07/29/25 at 11:04am revealed:
-He needed to go to the bathroom.
-He did not know when he last had a bowel movement, but he needed to go.
-"I need to get it out of me."
-He did not know if he was administered miralax.

Interview with the medication aide (MA)/Supervisor-in-Charge (SIC) on 07/29/25 at 5:16pm revealed:
-He administered the residents' medications every morning between 7:30am-8:00am.
-He administered Resident #1's miralax every day.
-He administered Resident #1's miralax based on the MAR and the medication on hand.
-He did not know why Resident #1 had more miralax on hand than there should be if it was administered every day.

Telephone interview with the Administrator on 07/31/25 at 11:08am revealed:
-She did not recall seeing multiple different orders for Resident #1's miralax.
-She recalled Resident #1 having an as needed dose, then it was changed to daily, and then was changed back to as needed, she thought.

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C 315	Continued From page 78 Telephone interview with a representative from Resident #1's PCP's office on 07/29/25 at 2:53pm revealed the nurse practitioner was not in the office that week. Telephone interview with Resident #1's PCP on 07/29/25 at 3:04pm revealed he did not think Resident #1 would be able to cognitively tell the MA he needed miralax, which put the resident at risk for constipation.	C 315		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were documented immediately after administration for 3 of 3 sampled residents. The findings are: Observation of the sister facility on 07/29/25 at 8:05am revealed:	C 341		

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BEVERLY RUCKER FAMILY CARE HOME #8	6878 NC HIGHWAY 150 REIDSVILLE, NC 27320

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C 341	Continued From page 79 -The MARs for the facility were on a table in a room in the sister facility. -All of the residents' MARs were kept together in one book -There was no documentation on the MARs for administration of medications for the residents for the evening medications on 07/28/25 and for the morning medications on 07/29/25. Review of three residents' July 2025 MAR on 07/29/25 at 8:16am revealed none of the medications for the three residents had been documented as administered for the 8:00pm medications on 07/28/25 and the 8:00am medications on 07/29/25. Interview with a resident on 07/29/25 at 8:15am revealed the MA from the sister facility administered his medications; he had already received his medications for today 07/29/25. Interview with a second resident on 07/29/25 at 11:04am revealed he did not know the name of the medication aide (MA) who administered his medications today, 07/29/25. Interview with the MA/Supervisor-in-Charge (SIC) on 07/29/25 at 8:05am revealed: -He worked in the sister facility next door as the SIC/MA. -He prepared and administered medications to the residents in the facility and the sister facility next door where he worked. -He came to the facility and administered the residents their medications. -The residents' MARs were in a book and were usually kept in the facility with the residents' medications. -He had already administered the residents their medications this morning, 07/29/25.	C 341		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL017037	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 341	Continued From page 80 Interview with the same MA on 07/30/25 at 3:30pm revealed: -He worked at the sister facility as the SIC. -He administered the residents' medications at both facilities. -He usually documented the residents' medications on the MAR after he administered everyone's medications. -If he did not document administering the medications on 07/28/25 and 07/29/25 it was because he forgot. Telephone interview with the Administrator on 07/31/25 at 11:08am revealed: -The MA should document on the MAR as soon as the resident's medications were administered. -The MA was supposed to document on the MAR before he administered another resident's medications. -The MA was trained to document immediately after administering medications; she did not know why he did not document like he was trained to do. -She had not observed the MA do a medication pass "lately". -She had not observed MA do a medication pass in "about 5 months".	C 341		