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BEVERLY RUCKER FAMILY CARE HOME #7	6878 NC HWY 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 and annual and a follow-up survey from 07/29/25 to 07/31/25.	C 000		
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, the facility failed to ensure a current fire inspection was 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 dated 08/15/23 revealed: -The fire inspection was completed by a 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. Telephone interview with a representative from the facility's fire inspection company on 07/30/25	C 034		

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C 034	Continued From page 1	C 034		

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.
-He told the Administrator he would not do another 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 11:58am revealed:
-She thought she had a current fire inspection for the facility.
-She had not paid any attention to the date on the

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C 034	Continued From page 2 inspection report. -She did not realize the inspection was from 2023. Telephone interview with the Administrator on 07/31/25 at 12:19pm revealed: -She knew a fire inspection was due annually. -She thought she had called and scheduled an appointment at some time, and she thought the inspector had been out in the last year. -She was not at the facility when they did the inspection in 2023. -She did not look at the inspection report. -She was not aware the facility did not pass the inspection. -She was responsible for scheduling the fire inspections for the facility, reviewing the report and making any needed corrections, were done.	C 034		
C 076	10A NCAC 13G .0315 (a)(3) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) A family care home shall: (3) have furniture that is clean, safe, and functional; 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: Based on observations, interviews, and record review, the facility failed to ensure the furniture in the television room was clean and in good repair	C 076		

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C 076	Continued From page 3 including two sofas, an upholstered chair and a recliner. The findings are: Observation of the facility's television room on 07/29/25 at 9:09am revealed: -There were two sofas, a chair and a recliner in the television room. -One sofa was upholstered, and the second one was a black sofa. -There were large areas of dark colored stains on the headrest, armrest and seat cushions of the upholstered sofa. -There were multiple dead bugs and debris under the cushions. -There were large areas of dark colored stains on the headrest, armrest and seat cushions of the chair. -There were sunken areas, dead bugs and debris under the seat cushions of the black sofa. -There was a large one-foot tear in the middle of the seat of the recliner; the tear had separated, and the springs and foam were visible. Interview with the Administrator on 07/29/25 at 9:50am revealed she had not gotten the dead bugs from under the cushions of the sofa since the pest control sprayed for bugs about a month ago. Telephone interview with the Administrator on 07/31/25 at 1:30pm revealed: -The sofa and the wingback chair in the television room needed to be replaced because she could not clean them. -She did not know when they would be replaced. The other sofa in the television room needed to be replaced because it was sagging. -She was aware the recliner in the television	C 076		

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C 076	Continued From page 4 room had a large tear in the seat and it also needed to be replaced.	C 076		
C 078	10A NCAC 13G .0315 (a)(5) Housekeeping and Furnishings 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, interviews and record reviews, the facility failed to maintain an environment that was clean and free from hazards as evidenced by an active infestation of bed bugs. 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 and where people slept. -Bed bugs hid during the day in the seams of	C 078		

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C 078	Continued From page 5 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, 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; they typically sprayed insecticides to treat the areas. Interview with the medication aide (MA) on 07/29/25 at 8:05am revealed there were three residents residing in the facility. Observation of resident room #1 on 07/29/25 at 12:30pm revealed: -There were brownish red spots on the pillow and the mattress cover on the bed; the sheets had been removed. -There were black spots and dead bed bugs in the seams of the mattress cover. -There were black spots on the headboard of the bed. -There were black spots, debris, and dead bed bugs on the floor around the legs of the bed and the headboard. Based on observations, interviews and record reviews it was determined the resident who resided in resident room #1 was not interviewable. Observation of resident room #3 on 07/29/25 at 9:30am revealed:	C 078		

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C 078	Continued From page 6 -There were multiple brownish red smears the size of a thumb on the wall next to the bed; they went down the full length of the bed and extended two feet up from the mattress. -The largest number of smears were on the wall near the head of the bed. -There were live and dead bed bugs on the walls beside the bed and behind the headboard. -There were brownish red spots on the pillow and sheets on the bed. -There were live bed bugs on the mattress, in the sheets and on the comforter on the bed. -There were clusters of black spots, live and dead bed bugs in the seams of the wall and the corners of the room near the ceiling. -There was an electrical conduit that came from the ceiling and ran down the length of the wall to an electrical outlet next to the bed. -There were clusters of black spots, live and dead bed bugs along the conduit and the electrical plug. -There were black spots on the headboard of the bed. -There were black spots, debris, and dead bed bugs on the floor around the legs of the bed and the headboard. -There were dead bedbugs on the walls beside the bed and on the wall behind the headboard. Interview with the resident who resided in resident room #3 on 07/29/25 at 9:30am revealed: -There were smears on the wall because he had squished bed bugs at night to kill them. -The smears had been on the wall for about a week. -There were dead bugs on other parts of the wall that had been there for about a year. -He would see the live bed bugs crawling on the walls at night. -He saw them and felt them in his bed.	C 078		

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C 078	Continued From page 7 -He saw live bed bugs on the walls and on his bed during the day. -The facility needed to hire a professional to kill the bed bugs. -He had seen live bed bugs for about a year. -The facility staff set off [fumigation] bombs to kill the bed bugs. -The bombs would kill the bed bugs for a few days, and they would come back out. -The facility staff changed his bed sheets every couple of weeks. -The bed bugs had been in his room and in his bed for over a year; it was an ongoing battle. -He no longer complained to the Administrator because she had seen the bed bugs when she came into his room about once a month and she did nothing. Interview with the resident who resided in room three on 07/30/25 at 11:56am revealed he preferred to live in a clean environment; he lived in a clean place before he moved into the facility. Observation of resident room #4 on 07/29/25 at 12:35pm revealed: -There were multiple brownish red smears the size of a thumb on the wall next to the bed. -The largest number of smears were on the wall near the middle of the bed. -There were live and dead bed bugs on the walls beside the bed and behind the headboard. -There were brownish red spots on the pillow and sheets on the bed. -There were live bed bugs on the mattress, in the sheets and on the comforter on the bed. -There were clusters of black spots, live and dead bed bugs in the seams of the wall and the corners of the room near the ceiling. -There were brownish black spots on the curtains next to the bed.	C 078		

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C 078	Continued From page 8 -There were dead bed bugs, dust, debris and black specks on the floor behind the headboard, around the bed, and around the nightstand. -There were white disks under the legs of each bed post; the disks each had large numbers of dead and live bed bugs. -The resident who resided in room #4 pointed to the live bed bugs. Interview with the resident who resided in resident room #4 on 07/29/25 at 12:35pm revealed there were live bed bugs in her bed. Observation of the facility's television room on 07/29/25 at 9:09am revealed: -There were two sofas, a chair and a recliner in the television room. -One sofa was upholstered, and the second one was a black leather like sofa. -There were multiple dead bed bugs and debris under the cushions of both sofas. Interview with the Administrator on 07/29/25 at 9:50am revealed she had not cleaned the dead bugs from under the cushions of the sofa since the pest control sprayed for bugs about a month ago. 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 began treating the facility for bed bugs on 08/12/24. -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	C 078		

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was two months ago.
-He had given the Administrator a list of steps and 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 specific named 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 after everything was run in the dryer on high heat to then wash everything on high temperature setting and dry again on high heat.
-The key to killing live bed bugs, nits (young bed bugs), larva 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 on the clothes and bed sheets.
-He recommended placing clothing, bedsheets, and curtains in the dryer every other day without washing to kill live bed bugs between washing.
-A second step was to have the staff place items that could not be placed into the dryer into black 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

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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 the 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.
-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 beg bugs and they could not escape through the nylon so the stocking could slide off the attachment, be 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; 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

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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 it 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 treated one of the sofas in the television room in the facility because a resident from the sister facility had come over and sat on it and they had bed bugs in the sister facility.
-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 MA on 07/29/25 at 12:40pm revealed:
-He saw live bed bugs in resident rooms #3 and #4 today, 07/29/25.
-He washed the bed sheets for the resident in resident room #4 every day and washed the other residents' sheets about every two days.
-The pest control company treated the facility for bed bugs every four to six months.
-The residents would go to the sister facility for two to three hours while the facility was being treated.
-He was never told what to do before a treatment

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or after a treatment for bed bugs.
-He washed and dried the residents' sheets and clothes on the day of treatments.
-It took all day to wash and dry everything.

Interview with the MA on 07/30/25 at 4:20pm revealed:
-There was a spray the facility had to use for bed bugs, but the pest control technician told them not to use it because it interfered with the spray he used.
-They had a brand name bomb the staff used to treat bed bugs; they used them every six months.
-He was not told to do anything between bed bug treatments done by the pest control company.
-He was not told to vacuum furniture or mattresses; the facility did not have a vacuum.
-He was not told to dry the residents' clothes in a dryer on high heat first before washing them.
-The Administrator told him yesterday to wash all the residents' clothes and sheets because of the bed bugs.
-The Supervisor-in-Charge (SIC) from the sister facility took everything to the laundromat and dried them in the dryer.
-The facility did not have a dryer; they usually hung everything on the clothesline to dry.

Observation of the bed bug spray on 07/30/25 at 4:44pm revealed:
-The spray was 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 Administrator on 07/29/25 at 11:58am revealed:
-The pest control company had been treating the facility for bugs for about a year; including bed bugs.

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C 078	Continued From page 13 -The pest control company treated the facility every two to three months for bed bugs. -The pest control company said the treatments were effective because the bed bugs crawled across the solution they sprayed. -The pest control technician told her not to allow the facility staff to spray any other chemicals for bed bugs, because it would interfere with the chemical that the pest control company used. -The pest control technician did not leave any reports or tell her where they saw bed bugs. -The only thing the pest control technician told her to do was clean with bleach between treatments. -She was in the facility once a week and inspected it for bed bugs about every two weeks or when staff told her they saw them. -The residents had not told her they had bed bugs in their rooms. -About a week ago the staff reported they had seen bed bugs in resident room three. -The staff had not seen bed bugs anywhere else in the facility. -She last looked for bed bugs about two weeks ago; she had not had the chance to look since a staff told her about resident room three. -Every three months she took the residents' clothing and sheets and put them in a dryer on high heat. -She took the residents to another sister facility for about three hours while the pest control technician treated the facility. -She had not been told what to do about the furniture. Telephone interview with the Administrator on 07/30/25 at 9:29am revealed: -She did not have a clothes dryer at the facility. -The staff took all the laundry to the laundry mat to dry after they washed it. -She was never told that to kill bed bugs	C 078		

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	FCL017036	A. BUILDING: _____ B. WING _____	R 07/31/2025

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C 078	Continued From page 14 everything had to be dried in the dryer on high heat prior to washing. -She thought all she had to do was wash and then dry the sheets and clothes on high heat to kill the bed bugs. _____ The facility failed to ensure 3 of 3 residents were provided with a clean, clutter free and hazard free environment, as evidence of an active infestation of live bed bugs. This failure resulted in serious physical harm and neglect which constitutes an 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 082	10A NCAC 13G .0315 (a)(9) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) A family care home shall: (9) have curtains, draperies, or blinds at windows in resident use areas to provide for resident privacy; 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: Based on observations and interviews, the facility failed to ensure windows and windowsills were	C 082		

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C 082	Continued From page 15 kept clean in three resident rooms. The findings area: Observation of resident room #1 on 07/29/25 at 12:40pm revealed there were dead flies, black dust and debris on the windowsill next to the bed. Observation of resident room #3 on 07/29/25 at 9:30am revealed: -There were two windows in the room. -There were dead flies, black dust and debris on the windowsill next to the bed. -There was a dead fly, a dried leaf, hair, black dust and debris on the windowsill next to the dresser. Observation of resident room #4 on 07/29/25 at 12.50am revealed: -There were two windows in the resident room. -There was debris and black dust on the windowsill. -There was a large black smear on one window, multiple black spots and coating of film and dirt that obstructed the view out of the window. -There was a black film that coated the casing of the windows. Interview with the resident who resided in room #3 on 07/30/25 at 11:56am revealed: -His windowsills had been dirty for a long time. -He did not like the dirt in the windows, and he wished it was clean. -He did not tell the staff he wanted his windows clean; he felt like they did not care. -He had not seen the Administrator in his room in so long he could not remember the last time she was in his room. -He preferred to live in a clean environment; he lived in a clean place before he moved into the	C 082		

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C 082	Continued From page 16 facility. Interview with the medication aide (MA) on 07/30/25 at 4:01pm revealed: -The Administrator came to the facility about once a week and sometimes more. -She did not always go into the residents' rooms. -He had never cleaned the windows in the residents' rooms. -About six months ago he wiped the windowsills off. -The facility did not have a cleaning schedule or a cleaning list for the residents' rooms. -He looked to see what needed to be cleaned and he cleaned it. -The residents had never complained about the windows being dirty. Telephone interview with the Administrator on 07/31/25 at 1:30pm revealed: -The staff should be wiping the windowsills with their daily cleaning. -Sometimes she would have to remind them. -The glass in the windows should be cleaned when the staff noticed they were dirty. -She looked at the windows in the residents' rooms when she went into the facility at least once a month. -She had not checked the windows in the residents' rooms to see if the staff needed to clean it in the last three months. -The last time the windows had been washed was in April 2025 and they should have been done again since then. -The staff should be washing the inside and the outside of the windows. Based on observations, interviews, and record reviews it was determined the resident who resided in room #1 and the resident who resided	C 082		

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C 082	Continued From page 17 in room #4 were not interviewable.	C 082		
C 088	10A NCAC 13G .0315 (b)(3) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (3) chest of drawers or bureau when not provided as built ins, or a double chest of drawers or double dresser for two residents; 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: Based on observations and interviews, the facility failed to ensure a dresser was provided that was in good repair for a resident who had a dresser with a missing handle and drawers that would fall out when pulled opened. The findings are: Observation of resident room #3 on 07/30/25 at 12:29pm revealed: -There was a single tall dresser with five drawers in the resident room. -There was a missing handle pull on the top drawer of the dresser; the handle was broken off. -The drawers were not secured with interlocking top and bottom tracks so when a drawer was pulled open it tilted forward and would fall out of the dresser.	C 088		

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C 088	Continued From page 18 -There were five bottom tracks in the dresser, but the drawers did not have the corresponding piece of track attached to them to prevent them from falling out when opened. -There were clothes in the drawers. Interview with the resident who resided in resident room #3 on 07/30/25 at 11:56am revealed: -He opened the top dresser drawer by grabbing the sides of the drawer with both hands and pulling. -His dresser drawers were broken and would fall out when he went to open them because they did not have the bottom track on the drawers. -He had to be careful not to pull the drawers out too far because he was afraid one might fall on him and they were heavy. -The dresser drawers had been without the handle and the tracks since he was given the dresser over a year ago. -He stopped complaining about the broken handle and the dresser drawers to the staff and the Administrator a long time ago because it was never fixed or replaced. -He felt like the Administrator did not want to know about broken furniture because she did not want to fix it. -The Administrator did not come into his room and look at his furniture or at the bed bugs. -He could not remember the last time he had seen the Administrator in his room it was so long ago. Telephone interview with the Administrator on 07/31/25 at 1:30pm revealed: -She did not know the handle pull on the dresser in resident room #3 was broken off. -She was not aware that the drawers in the dresser in resident room three were falling out when pulled open	C 088		

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C 088	Continued From page 19 -The resident who resided in the room had not complained and staff had not told her. -All the staff had to do was tell her when something was broken and she would take care of it.	C 088		
C 090	10A NCAC 13G .0315 (b)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (5) a minimum of one chair that is comfortable as preferred by the resident, which may include a rocking or straight chair, with or without arms, that is high enough for the resident to easily rise without discomfort; 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: Based on observations and interviews, the facility failed to ensure the chair in resident room four was in good repair. The findings are: Observation of resident room #4 on 07/30/25 at 11:53am revealed: -There was a wooden rocking chair with a woven wicker seat. -The seat was sunken and most of the wicker was broken and missing.	C 090		

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C 090	Continued From page 20 Interview with the medication aide (MA) on 07/30/25 at 4:01pm revealed: -He noticed the broken chair in resident room #4 yesterday, 07/29/25. -He had not had a chance to tell the Administrator about the broken chair because he had been busy. -He did a weekly inspection and reported anything that was broken to the Administrator. -The resident who resided in room #4 had not complained about the broken chair. -The Administrator came to the facility about once a week and sometimes more. -She did not always go into the residents' rooms. Telephone interview with the Administrator on 07/31/25 at 1:30pm revealed: -She was not aware that the chair in resident room #4 was broken. -She would need to throw the chair away. -The staff had not told her that the weave in the seat was broken. -The staff should have let her know. -All the staff had to do was tell her when something was broken and she would take care of it. -The resident who resided in room #4 had not complained and staff had not told her. Based on observations and interviews, the resident who resided in resident room #4 was not interviewable.	C 090		
C 093	10A NCAC 13G .0315 (b)(8) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings	C 093		

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C 093	Continued From page 21 (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (8) a light overhead of bed with a switch that may be reached by a person lying on the bed; or a lamp. The light shall provide a minimum of 30 foot candle power of illumination for reading. 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: Based on observations and interviews, the facility failed to ensure there was a working lamp that could be reached by the resident while lying in bed. The findings are: Observation of resident room #4on 07/30/25 at 12:58pm revealed: -There was a bedside lamp in the room. -The lamp was plugged into an outlet. -The top part of the lamp was hanging down beside the base of the lamp. -The neck of the lamp where the on/off switch and light bulb socket was pulled up and out of the base of the lamp. -The cords to the switch and socket were exposed and the lampshade was still on the light bulb. Interview with the medication aide (MA) on 07/30/25 at 4:01pm revealed: -He noticed the broken lamp in resident room #4 yesterday, 07/29/25. -He had not had a chance to tell the Administrator about the broken lamp because he had been busy.	C 093		

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C 093	Continued From page 22 -He did a weekly inspection and reported anything that was broken to the Administrator. -The resident who resided in room #4 had not complained about the lamp. -The Administrator came to the facility about once a week and sometimes more. -She did not always go into the residents' rooms. -She would stay from a few minutes to an hour when she was at the facility. Telephone interview with the Administrator on 07/31/25 at 1:30pm revealed: -All the staff had to do was tell her when something was broken and she would take care of it. -She was not aware of the broken lamp in resident room #4. -The resident who resided in room #4 had not complained and staff had not told her. Based on observations, record reviews, and interviews, the resident who resided in resident room #4 was not interviewable.	C 093		
C 104	10A NCAC 13G .0317 (c) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (c) The facility shall have heating and cooling systems such that environmental temperature controls are capable of maintaining temperatures in the home at 75 degrees F minimum in the heating season, and not exceed 80 degrees F during the non-heating season.	C 104		

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C 104	Continued From page 23 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews the facility failed to ensure the temperature inside the facility was maintained and did not go over 80 degrees Fahrenheit (F) during the summer cooling season. Review of the National Weather Service local temperature records for dates 07/25/25 to 07/30/25 revealed: -The temperature records for the facility's local area were recorded at the highest time and temperature and lowest time and temperature of the day. -On 07/25/25, at 5:29pm the high was 91 degrees F and at 5:46am the low was 72 degrees F. -On 07/26/25, at 1:43pm the high was 95 degrees F and at 5:53am the low was 76 degrees F. -On 07/27/25, at 1:53pm the high was 95 degrees F and at 5:40am the low was 76 degrees F. -On 07/28/25, at 4:28pm the high was 93 degrees F and at 5:53am the low was 75 degrees F. -On 07/29/25, at 12:42pm the high was 91 degrees F and at 6:11am the low was 75 degrees F. -On 07/30/25, at 2:58pm the high was 91 degrees F and at 5:40am the low was 73 degrees F. Observation of the facility on 07/29/25 at various times from 8:00am to 7:00pm revealed: -There were two thermostats in the facility. -There was a thermostat on the wall in the television room with a clear locked cover on it. -There was a piece of paper inside the locked cover and the settings on the thermostat were not	C 104		

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C 104	Continued From page 24 visible due to the paper. -There was a solid tan box that was locked and mounted to the wall in the kitchen. -The thermostat could not be seen, and the settings could not be read with the cover on. -The air inside the facility was hot and humid. -There was an oscillating tower fan running in the television room. Observations of the facility on 07/30/25 at various times from 8:00am to 5:30pm revealed: -The air inside the facility was hot and humid. -At 12:50pm, a resident broke the glass in a window in her room when she attempted to open it. -She placed the large pieces of broken glass in the trash can in her room. -There were large pieces of broken glass still in the frame of the window; the window was not open. -At 1:50pm, the thermostat cover was opened by the medication aide (MA) and the temperature was 83 degrees F and the thermostat was set at 63 degrees F. -At 4:01pm, the thermostat was set at 63 degrees F, and the temperature was 85 degrees F. -At 1:50pm and 4:01pm, the air conditioner technician used his thermometer to get a temperature reading of the ambient air in the facility; his thermometer read 85 degrees F both times. Interview with a resident on 07/29/25 at 4:00pm revealed: -The facility had been very hot for the past two weeks. -A new air conditioner was put in and it was nice for a few days and then it got hot in the facility. -He complained to the medication aide (MA) about the heat.	C 104		

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C 104	Continued From page 25 -The MA told him he would let the Administrator know about the heat. -He did not hear anything else, and it continued to be hot. -He had not seen the Administrator at the facility since it had been hot. -The temperature in the facility was so hot, it was miserable. Interview with a second resident on 07/29/25 at 1:50pm revealed: -It was too hot to stay inside the facility. -Her room was hot. -She went outside and sat because it was cooler outside than inside. Interview with the second resident on 07/30/25 at 12:50pm revealed: -She was hot, so she tried to open the window in her room and the [glass] window broke. -She wanted to get some air in her room. -It was cooler outside than it was in the facility, but she did not want to sit outside all day. Interview with the air conditioner technician on 07/30/25 at 1:50pm revealed: -The air conditioner at the facility was new. -The facility called yesterday, 07/29/25, about the air conditioner not working. -He was scheduled to do the repair at the facility that afternoon, 07/30/25. -He did not have a key to the thermostat covers. -He could take the temperature of the ambient air inside the facility with his thermometer. -He used the thermometer to monitor inside temperatures. -The air conditioner was not cooling the inside of the facility because the compressor had frozen. -He could not say how long the compressor was frozen.	C 104		

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C 104	Continued From page 26 -The air conditioner needed a replacement part; he would get the part and return later to repair the air conditioner today, 07/30/25. Interview with the MA on 07/29/25 at 4:01pm revealed: -The air conditioner was running fine after it was installed and it felt nice and cool in the facility. -Then about two weeks ago it got hotter inside. -He did not know what temperature the thermostat was set on. -The Administrator set the temperature on the thermostat. -The thermostat was on the wall in the kitchen and had a locked box covering it. -He did not have access to the key for the lock box on the thermostat. -The Administrator was the only one with the key to the lock box covering the thermostat. -He thought the air conditioner was currently running but it did not feel cool inside. -The residents had not complained about the heat. -He told the Administrator it had gotten warmer in the facility. -She came to the facility about two or three weeks ago and adjusted the thermostat to the air conditioner. -It was still hot in the facility; he had not had a chance to let her know it was hot in the facility. Interviews with the MA on 07/30/25 at 11:43am and 12:50pm revealed: -He had not seen a repairman for the air conditioner. -He had not seen the Administrator today, 07/30/25. -It was still hot in the facility. -The resident in room four was trying to open her window because she said she was hot and was	C 104		

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BEVERLY RUCKER FAMILY CARE HOME #7	6878 NC HWY 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 104	Continued From page 27	C 104		

trying to get some air in her room.
-He thought the facility was hot yesterday 07/29/25, and today 07/30/25.
-He told the Administrator yesterday that it was hot in the facility.
-The Administrator came to the facility around 7:30pm last night,07/29/25.
-She unlocked and opened the cover to the thermostat.
-He saw the thermostat when the Administrator uncovered it; the thermostat was set at 69 degrees F and the temperate was 73 degrees F.
-He did not know if she adjusted the temperature on the thermostat while she had it opened.

Telephone interview with the Administrator on 07/29/25 at 4:05pm revealed:
-She did not know what temperature the thermostat for the air conditioner was set on.
-She had a new air conditioner installed at the beginning of July 2025.
-None of the residents had told her it was hot inside the facility since she had the new air conditioner installed.
-Staff had not told her the residents had complained.
-A resident complained about the heat before the facility got the new air conditioner.
-The company who installed the air conditioner set the temperature on the thermostat.
-She had not touched the thermostat since the new air conditioner was installed.
-The company that installed the air conditioner had the key to the locked box on the thermostat.
-She covered the thermostats because the residents would see the temperature and want to change it.
-She did not ask the residents about the temperature in the facility.
-She asked the residents if they were comfortable

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C 104	Continued From page 28 or not. -She called the company that installed the air conditioner, and they would be at the facility the next morning to repair the air conditioner. Telephone interview with the Administrator on 07/30/25 at 1:03pm revealed: -She brought the key for the thermostat box yesterday evening, 07/29/25. -She did not adjust the thermostat when she opened the cover. -The thermostat was set at 60 degrees F, and the temperature reading was 73 degrees F. -She contacted a repair company the day before to look at the air conditioner today, 07/30/25. -The air conditioning company told her they would be at the facility in the afternoon on 07/30/25 to look at the air conditioner. _____ The facility failed to ensure the inside temperature of the facility was maintained and did not go over 80 degrees Fahrenheit (F) during summer conditions for the residents where inside temperatures were observed at 85 degrees F and outside recorded temperature highs were 95 and lows were 76. The residents had complained, and one resident sat outside because it was cooler than the inside temperature of the facility. This failure was detrimental to the health and safety of the residents and constitutes a Type B 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 104		

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C 131	Continued From page 29	C 131		
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. 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.	C 131		

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C 131	Continued From page 30 Review of residents' medication administration records (MAR) for April 2025-July 2025 revealed Staff A documented he administered the residents' medications. Interview with two residents on 07/29/25 from 8:05am-9:00am revealed Staff A administered medications. Interview with the SIC at the sister facility on 07/29/25 at 8:10am revealed Staff A, administered the residents' medications at this facility. Interview with Staff A on 07/30/25 at 3:30pm revealed: -He worked at the facility as the MA/SIC and administered medications at the sister facility. -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	C 131		

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C 131	Continued From page 31 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 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 had been about "about 5 months". [Refer to 10A NCAC 13G .1004(a) Medication Administration] [Refer to 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 resulted 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	C 131		

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C 131	Continued From page 32 07/30/25. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON JULY 31, 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. 131E-256; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that 1 of 2 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	C 145		

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C 145	Continued From page 33 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 verification 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		
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 1 of 2 sampled (Staff A) had an examination and screening for the presence of controlled substances completed upon hire. The findings are: Review of Staff A's, medication aide (MA)/Supervisor-in-Charge (SIC) personnel	C 148		

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C 148	Continued From page 34 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		
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 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	C 185		

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C 185	Continued From page 35 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 management and operation of the facility were implemented to maintain each resident's rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to design and construction, 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 Healthcare Profesional Suport (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 residents could lead to a negative outcome.	C 185		

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C 185	Continued From page 36 -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 a resident on 07/29/25 at 9:45am revealed: -He saw the Administrator in the facility about once a month. -She would come into his room but did not speak to him. -He had not seen the Administrator in his room in so long he could not remember the last time she was in his room. -He stopped complaining about things to her because she made him feel like she did not care. Interview with the medication aide (MA) on 07/30/25 at 4:01pm revealed: -The Administrator came to the facility about once a week and sometimes more. -She did not always go into the residents' rooms. -She did not always talk to the residents. -She would stay from a few minutes to an hour when she was at the facility. -She would look at the medication administration records (MAR) records and she would look at the medications. -She would ask him how everything was going. -He called the Administrator when he had any concerns with residents or any questions. 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.	C 185		

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C 185	Continued From page 37 -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 MAR, checked the medications and sometimes she went into the residents' rooms to see if they were clean. Noncompliance identified during the survey included: 1. Based on observations, interviews and record reviews, the facility failed to ensure residents were observed taking their medications, medications were documented immediately after administration by the staff who prepared and administered the medications to 2 of 2 residents (#1 and #2) who took the wrong medications. [Refer to Tag C 341, 10A NCAC 13G .1004(i) Medication Administration (Type A1 Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to maintain an environment that was clean and free from hazards as evidenced by an active infestation of bed bugs. [Refer to Tag C 078, 10A NCAC 13G .0315(a) Housekeeping and Furnishings (Type A1 Violation)]. 3.Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#1 and #3) including medication for memory loss, a prostate medication, and a Vitamin (#1) and a quick-acting insulin and a long-acting insulin (#3). [Refer to Tag C 330, 10A NCAC 13G .1004(a) Medication Administration (Type A2 Violation)].	C 185		

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C 185	Continued From page 38 4. Based on observations and interviews the facility failed to ensure the temperature inside the facility was maintained and did not go over 80 degrees Fahrenheit (F) during the summer cooling season. [Refer to Tag C 104, 10A NCAC 13G .0317(c) Building Service Equipment (Type B Violation)]. 5. 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)]. 6. Based on observations, record reviews, and interviews, the facility failed to ensure all food items stored in the facility were protected from contamination related to live bugs in a food storage bin and inside food storage containers in the kitchen. Refer to Tag C 257, 10A NCAC 13G .0904(a)(1) Nutrition and Food Service (Type B Violation)]. 7. Based on observations and interviews, the facility failed to ensure each resident was treated with respect and dignity, as evidenced by the residents who were bitten by bed bugs, could not sleep at night because the live bed bugs biting them and the residents who resided in the facility had to go to the sister facility when the facility did not have staff or when the facility was sprayed for bed bugs. [Refer to Tag C 311, 10A NCAC 13G .0909 Residents' Rights (Type B Violation)]. 8. Based on interviews and record reviews, the facility failed to ensure a current fire inspection	C 185		

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C 185	Continued From page 39 was available for review. [Refer to Tag C 034, 10A NCAC 13G .0302(n) Design and Construction (Standard Deficiency)]. 9. Based on observations, interviews, and record review, the facility failed to ensure the furniture in the television room was clean and in good repair including two sofas, an upholstered chair and a recliner. [Refer to Tag C 076, 10A NCAC 13G .0315(a)(3) Housekeeping and Furnishings (Standard Deficiency)]. 10. Based on observations and interviews, the facility failed to ensure windows and windowsills were kept clean in three resident rooms. [Refer to Tag C 082, 10A NCAC 13G .0315(a)(9) Housekeeping and Furnishings (Standard Deficiency)]. 11. Based on observations and interviews, the facility failed to ensure a dresser was provided that was in good repair for a resident who had a dresser with a missing handle and drawers that would fall out when pulled opened. [Refer to Tag C 088, 10A NCAC 13G .0315(b)(3) Housekeeping and Furnishings (Standard Deficiency)]. 13. Based on observations and interviews, the facility failed to ensure the chair in resident room four was in good repair. [Refer to Tag C 090, 10A NCAC 13G .0315(b)(5) Housekeeping and Furnishings (Standard Deficiency)]. 14. Based on observations and interviews, the facility failed to ensure there was a working lamp that could be reached by the resident while lying in bed. [Refer to Tag C 093, 10A NCAC 13G .0315(b)(8) Housekeeping and Furnishings	C 185		

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C 185	Continued From page 40 (Standard Deficiency)]. 15. Based on record reviews and interviews, the facility failed to ensure that 1 of 2 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)]. 16. Based on interviews and record reviews, the facility failed to ensure that 1 of 2 sampled (Staff A) 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)]. 17. Based on observations, interviews, and record reviews, the facility failed to ensure physician notification for 1 of 3 sampled residents (#3) related to finger stick blood sugar (FSBS) results over 300. [Refer to Tag C 246, 10A NCAC 13G .0902(b) Health Care (Standard Deficiency)]. 18. Based on observation, interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 3 sampled residents (#3) related to giving orange juice and rechecking finger stick blood sugars (FSBS) when results were below 70. [Refer to Tag C 249, 10A NCAC 13G .0902(b)(3-4) Health Care (Standard Deficiency)]. 19. Based on observations, record reviews, and interviews, the facility failed to follow-up on recommendations made by the Licensed Health Professional Support (LHPS) nurse for 1 of 2 sampled residents (#1) related to a walker and cutting fingernails and toenails. [Refer to Tag C	C 185		

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BEVERLY RUCKER FAMILY CARE HOME #7	6878 NC HWY 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 41 255, 10A NCAC 13G .0903(d) Health Care (Standard Deficiency)]. 20. 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)]. The Administrator failed to ensure the overall management and operation of the facility was 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. There was a bed bug infestation and residents wre being bitten by bed bugs. Medications were not being administered correctly and residents were not boserved taking their medications resulting in residents mixing up their medications. Additionally, the residents were required to go to the sister facility when no staff was in the facility. This failure resulted in serious physical harm and neglect which constitutes an A1 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 185		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care	C 246		

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C 246	Continued From page 42 (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: Based on observations, interviews, and record reviews, the facility failed to ensure physician notification for 1 of 3 sampled residents (#3) related to finger stick blood sugar (FSBS) results over 300. The findings are: Review of Resident #3's current FL2 dated 07/03/25 revealed diagnoses included bilateral deafness, hypertension and type two diabetes. Review of a Resident #3's signed physician's order dated 07/03/24 revealed there was an order for FSBS four times daily and to notify the physician for results over 300. Review of a Resident #3's signed physician's order dated 11/12/24 revealed there was an order for FSBS four times daily and to notify the physician for results over 300. Review of Resident #3's May 2025 medication administration record (MAR) revealed: -There was an entry to check FSBS four times daily before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was documentation FSBS were checked four times daily; the FSBS results were not documented on the entry. -There was an entry for Novolog 100units/ml inject three times day before eating per SS for reading 251-300, give 30 units; notify physician for FSBS over 300, scheduled at 8:00am, 12:00pm, and 5:00pm.	C 246		

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C 246	Continued From page 43 Review of Resident #3's May 2025 FSBS and SSI log revealed: -There were instructions to check Resident #3's FSBS at breakfast, lunch and dinner; to reference the SS. -There was documentation Resident #3's FSBS checks were done 93 of 93 opportunities. -Resident #3's FSBS results were documented over 300 two times. -Examples are as follows: -On 05/07/25, FSBS was 611. -On 05/08/25, FSBS was 452. Review of Resident #3's June 2025 MAR revealed: -There was an entry to check FSBS four times daily before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was documentation FSBS were checked four times daily; the FSBS results were not documented on the entry. -There was an entry for Novolog 100units/ml inject three times day before eating per SS for reading 251-300, give 30 units; notify physician for FSBS over 300, scheduled at 8:00am, 12:00pm, and 5:00pm. Review of Resident #3's June 2025 FSBS and SSI log revealed: -There were instructions to check Resident #3's FSBS at breakfast, lunch and dinner; to reference the SS. -There was documentation Resident #3's FSBS checks were done 92 of 93 opportunities from 06/01/25 to 06/30/25. -Resident #3's FSBS results were documented over 300 five times. -Examples are as follows: -On 06/05/25, FSBS was 405.	C 246		

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C 246	Continued From page 44 -On 06/15/25, FSBS was 356. -On 06/21/25, FSBS were 317, and 341. -On 06/22/25, FSBS was 367. -On 06/26/25, FSBS was 320. Review of Resident #3's July 2025 MAR from 07/01/25 to 07/30/25 revealed: -There was an entry to check FSBS four times daily before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was documentation FSBS were checked four times daily; the FSBS results were not documented on the entry. -There was an entry for Novolog 100units/ml inject three times day before eating per SS for reading 251-300, give 30 units; notify physician for FSBS over 300, scheduled at 8:00am, 12:00pm, and 5:00pm. Review of Resident #3's July 2025 FSBS/sliding scale (SSI) log from 07/01/25 to 07/30/25 revealed: -There were instructions to check Resident #3's FSBS at breakfast, lunch and dinner; to reference the SS. -There was documentation Resident #3's FSBS checks were done 90 of 90 opportunities from 07/01/25 to 07/30/25. -Resident #3's FSBS results were documented over 300 two times. -Examples are as follows: -On 07/23/25, FSBS was 462. -On 07/28/25, FSBS was 317. Telephone interview with a certified medical assistant (CMA) at Resident #3's primary care provider's (PCP) office on 07/31/25 at 12:56pm revealed: -The PCP wanted to be notified if Resident #3's FSBS results were over 300 because he could	C 246		

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C 246	Continued From page 45	C 246		

give instructions to the staff to adjust her medication.
-Notifying the PCP when FSBS results were over 300 also let him know if the resident was having continuing issues with her FSBS levels and he would follow up with the resident to see if she was compliant with her SSI.
-The PCP expected Resident #3's orders to be followed.

Interview with the medication aide (MA) on 07/30/25 at 2:25pm revealed:
-Resident #3 had an order for FSBS four times a day.
-Resident #3 never complained about feeling sick or jittery.
-He would call the Administrator if Resident #3's FSBS results were over a certain amount; 400 to 500 was too high.
-He had not notified the Administrator because Resident #3's FSBS results were never too high.
-The Administrator would contact the physician.
-He had not read the order on the MAR to notify the PCP if Resident #3's FSBS results were over 300.

Telephone interview with the Administrator on 07/31/25 at 1:17pm revealed:
-She audited the medication and the MARs once a month.
-Resident #3's FSBS results went up and down.
-She had not checked the FSBS/SSI logs in the last two or three weeks.
-She knew Resident #3 had a parameter for her SSI to call the physician if her FSBS results were over 300.
-The MA would call her first and she would call the physician.
-The PCP would tell her to give Resident #3 water and wait a few minutes.

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C 246	Continued From page 46 -The MA had called her when Resident #3's FSBS results were over 300, and she contacted the PCP. -She could not recall when or how many times she had contacted the PCP for FSBS, and she did not document the calls. -She did not think the MAs were calling her every time Resident #3's FSBS were over 300 so she could contact the PCP. -The MAs should have documented the calls; she had never told them to document the calls to her for FSBS results. -She was concerned they were not calling her because high FSBS results could affect Resident #3's health. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.	C 246		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 3 sampled residents (#3) related to giving orange juice and rechecking finger stick blood sugars (FSBS)	C 249		

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C 249	Continued From page 47 when results were below 70. The findings are: Review of Resident #3's current FL2 dated 07/03/25 revealed: -Diagnoses included bilateral deafness, hypertension and type two diabetes. -There was an order for sliding scale insulin (SSI) three times a day but there was no information for the sliding scale. Review of Resident #3's signed physician's order dated 11/12/24 revealed: -There was an order for FSBS four times daily before meals and at bedtime. -There was an order if FSBS were less than 70 to give four ounces of juice only, wait 15 minutes and recheck FSBS and repeat with another four ounces of juice if results were less than 70. Review of Resident #3's signed physician's order dated 07/03/25 revealed: -There was an order for FSBS four times daily before meals and at bedtime. -There was an order if FSBS were less than 70 to give four ounces of juice only, wait 15 minutes and recheck FSBS and repeat with another four ounces of juice if results were less than 70. Review of Resident #3's May 2025 medication administration record (MAR) revealed: -There was an entry to check FSBS four times daily before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm; if FSBS were less than 70 to give four ounces of juice only, wait 15 minutes and recheck FSBS and repeat with another four ounces of juice if results were less than 70. -There was documentation FSBS were checked	C 249		

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C 249	Continued From page 48 four times daily; the FSBS results were not documented on the entry. Review of Resident #3's May 2025 FSBS and SSI log revealed: -There were instructions to check Resident #3's FSBS at breakfast, lunch and dinner. -There was documentation Resident #3's FSBS checks were done 93 of 93 opportunities. -There were no FSBS results for Resident #3's for May 2025. Review of Resident #3's June 2025 MAR revealed: -There was an entry to check FSBS four times daily before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm; if FSBS were less than 70 to give four ounces of juice only, wait 15 minutes and recheck FSBS and repeat with another four ounces of juice if results were less than 70. -There was documentation FSBS were checked four times daily; the FSBS results were not documented on the entry. Review of Resident #3's June 2025 FSBS/SSI log revealed: -There were instructions to check Resident #3's FSBS at breakfast, lunch and dinner. -There was documentation Resident #3's FSBS checks were done 92 of 93 opportunities from 06/01/25 to 06/30/25. -Resident #3's FSBS results were documented below 70 five times. -Examples are as follows: -On 06/11/25, FSBS was 69. -On 06/15/25, FSBS was 63. -On 06/17/25, FSBS was 63. -On 06/23/25, FSBS was 64. -On 06/25/25, FSBS was 64.	C 249		

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C 249	Continued From page 49 Review of Resident #3's July 2025 MAR from 07/01/25 to 07/30/25 revealed: -There was an entry to check FSBS four times daily before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm; if FSBS were less than 70 to give four ounces of juice only, wait 15 minutes and recheck FSBS and repeat with another four ounces of juice if results were less than 70. -There was documentation FSBS were checked four times daily; the FSBS results were not documented on the entry. Review of Resident #3's July 2025 FSBS/SSI log from 07/01/25 to 07/30/25 revealed: -There were instructions to check Resident #3's FSBS at breakfast, lunch and dinner. -There was documentation Resident #3's FSBS checks were done 90 of 90 opportunities from 07/01/25 to 07/30/25. -Resident #3's FSBS results were documented below 70 five times. -Examples are as follows: -On 07/03/25, FSBS was 63. -On 07/05/25, FSBS was 67. -On 07/06/25, FSBS was 52. -On 07/08/25, FSBS was 66. -On 07/17/25, FSBS was 63. Telephone interview with a certified medical assistant (CMA) at Resident #3's primary care provider's (PCP) office on 07/31/25 at 12:56pm revealed: -Resident #3's had an order for FSBS results less than 70 to hold her NovoLog (a quick acting insulin used to lower FSBS) injection and to give juice. -Her FSBS should have been rechecked after giving juice to see if her blood sugar went up.	C 249		

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C 249	Continued From page 50 -If Resident #3 was not given juice her FSBS could continue to drop. -She could have symptoms including shakiness, weakness, sweating, irritability and she could pass out; she could end up in the hospital. -The PCP expected Resident #3's orders to be followed. Interview with the medication aide (MA) on 07/30/25 at 2:25pm revealed: -Resident #3 had an order for FSBS four times a day. -Resident #3 never complained about feeling sick or jittery. -He did not know the numbers but if Resident #3's FSBS results were in the double digits he knew her FSBS was too low, and he did not administer any insulin. -He documented a zero on the log under the amount of insulin administered. -He had never given Resident #3 any orange juice when her FSBS results were below a certain number. -He did not know he was supposed to give Resident #3 orange juice for FSBS results less than 70. -He had never read the order on the MAR to give Resident #3 juice and to recheck her FSBS. Telephone interview with the Administrator on 07/31/25 at 1:17pm revealed: -She audited the medication and the MARs once a month. -Resident #3's FSBS results went up and down. -She had not checked the FSBS/SSI logs in the last two or three weeks. -She knew the parameter for FSBS results were less than 70 and to give orange juice. -She had given the MA small cans of orange juice just for Resident #3.	C 249		

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C 249	Continued From page 51 -Resident #3 would get shaky and the orange juice would make her FSBS go to 90. -She also told the MA to give Resident #3 a peanut butter sandwich if they did not have any orange juice. -The order did not have anything about peanut butter, but she knew Resident #3 liked the peanut butter. -The MA had called her a couple of times to let her know he had to give Resident #3 something because her FSBS was less than 70. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.	C 249		
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 professional. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to follow-up on recommendations made by the Licensed Health Professional Support (LHPS) nurse for 1 of 2 sampled residents (#1) related to a walker and cutting fingernails and toenails. Review of Resident #1's current FL-2 dated 04/24/25 revealed diagnoses included metabolic	C 255		

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C 255	Continued From page 52 encephalopathy, chronic kidney disease, and dementia. a. Review of Resident #1's LHPS quarterly evaluation dated 02/27/25 revealed: -Resident #1's tasks included ambulation using assisted devices that required physical assistance. -There was documentation under progress evaluation notes that Resident #1 ambulated without an assistive device, but his gait was shuffled and required assistance from staff for safety. -There was documentation under recommendations that Resident #1 would benefit from the use of a standard walker due to his shuffling gait. Review of Resident #1's LHPS quarterly evaluation dated 05/05/25 revealed: -Resident #1's tasks included ambulation using assisted devices that required physical assistance. -There was documentation under progress evaluation notes that Resident #1 ambulated without an assistive device, but his gait was shuffled and required standby assistance from staff for safety. -There was documentation under recommendations that Resident #1 would benefit from the use of a standard walker due to his shuffling gait. Review of Resident #1's care plan dated 04/20/25 revealed he was independent with ambulation and locomotion and did not require staff assistance. Telephone interview with the facility's LHPS nurse on 07/29/25 at 2:00pm revealed:	C 255		

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C 255	Continued From page 53 -She recommended a walker because Resident #1 shuffled his feet and would get off balance. -Resident #1 walked very slowly and almost fall when standing. -Resident #1 would benefit from a walker because he could hold on to it for better balance. -She was not aware of Resident #1 having any falls. Interview with the medication aide (MA) on 07/29/25 at 4:20pm revealed: -Resident #1 did not use a walker to walk with. -Resident #1 took little steps when he walked. -Sometimes he needed help sitting or getting up from the chair or the bed. -Resident #1 would hold on to the wall or a chair when he walked. -Resident #1 had not fallen. Attempted telephone interview with Resident #1's primary care provider (PCP) on 07/29/25 at 2:50pm was unsuccessful. Based on observations, interviews and record reviews Resident #1 was not interviewable. Refer to the telephone interview with the facility's LHPS nurse on 07/30/25 at 10:00am. Refer to the telephone interview with the Administrator on 07/31/25 at 11:08am. b. Review of Resident #1's LHPS quarterly evaluation dated 05/05/25 revealed under recommendations there was documentation Resident #1's fingernails and toenails were long and to please have them trimmed as soon as possible. Review of Resident #1's care plan dated 04/20/25	C 255		

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C 255	Continued From page 54 revealed he required extensive assistance from staff with his grooming and personal hygiene. Observation of Resident #1 on 07/29/25 at 9:10am revealed: -He was sitting in a chair in the living room. -His fingernails extended past the tips of his finger by more than a quarter inch. -There were pointed corners, jagged edges and visible dirt and build-up under his fingernails. Telephone interview with the facility's LHPS nurse on 07/29/25 at 2:00pm revealed: -Resident #1 had requested to have his fingernails cut. -His fingernails and toenails were long. -She looked at his feet because his shoes did not fit and saw his toenails were long. Interview with the MA on 07/29/25 at 4:20pm revealed: -The staff cut the residents' fingernails and toenails when they needed them cut. -Sometimes the physician cut the residents' toenails. -He looked at the residents' nails and if they were long, he cut them. -When the resident's fingernail was past the tip of the finger by a half an inch he would cut them. -He cut Resident #1's fingernails and toenails. -He did not know the last time he cut Resident #1's fingernails, it had not been that long ago. Attempted telephone interview with Resident #1's primary PCP on 07/29/25 at 2:50pm was unsuccessful. Based on observations, interviews and record reviews Resident #1 was not interviewable.	C 255		

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C 255	Continued From page 55 Refer to the telephone interview with the facility's LHPS nurse on 07/30/25 at 10:00am. Refer to the telephone interview with the Administrator on 07/31/25 at 11:08am. _____ Telephone interview with the facility's LHPS nurse on 07/30/25 at 10:00am revealed: -She made recommendations on her LHPS evaluations to help residents. -She told the Administrator about any recommendation she made on her LHPS evaluations after every visit. -She felt like she was repeating the same recommendations to the Administrator for the same residents "over and over again". 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.	C 255		
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions.	C 257		

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C 257	Continued From page 56	C 257		

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

Based on observations, record reviews, and interviews, the facility failed to ensure all food items stored in the facility were protected from contamination related to live bugs in a food storage bin and inside food storage containers in the kitchen.

The findings are:

Observation of the facility's food storage areas on 07/29/25 at 8:50am revealed:
-There were two plastic storage totes stacked together in the corner of the medication room.
-The lids to the totes were closed with zip ties.
-The Administrator cut the zip ties and opened the top tote.
-There were two boxes of macaroni and cheese, three bags of dried beans, a bag of dried pasta and multiple canned vegetables, tuna and fruit in the tote.
-There were live and dead weevils on the boxes of macaroni and cheese.
-There were live weevils on the bags of dried beans and dried pasta.
-There was a hole in one of the bags of beans.

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C 257	Continued From page 57 -There were live weevils and dead weevils on the tops of the canned food and in the bottom of the tote. -There was a cabinet in the kitchen above the microwave that stored packages of dry drink mix, oatmeal, and food storage containers of rice, and grits. -There was a clear canister of grits, the lid was not secure and there were live bugs in the grits. -There was a round cardboard canister of oatmeal with a lid; there were live bugs in the oatmeal. -There were clusters of black specks on the shelves and on the packages of drink mix. Review of the Centers for Disease Control and Prevention (CDC) recommendations for dealing with weevils in food supplies revealed: -The recommendations were not dated. -Weevils were not known to transmit diseases to humans but would reduce the quality of food once infested. -Once weevils were discovered in the food it would be considered contaminated. -The CDC recommended immediately discarding contaminated food and removing it from the facility. -Thoroughly clean food storage areas by removing all items, and vacuuming shelves, corners, and crevices. -Dispose of the vacuum bag and contents by removing from the facility. -Food preparation surfaces and food storage areas should be wiped clean with hot soapy water and a disinfecting spray. -For severe or persistent infestations, contacting a professional pest control service should be considered. Telephone interview with the pest control	C 257		

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C 257	Continued From page 58	C 257		

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 not been told there were weevils in the kitchen or in the food.
-Weevils could get into food and the food should be dumped out.
-The cabinets and other food storage areas should be vacuumed and sanitized.
-Opened food should be stored in airtight containers and used quickly.

Interviews with the medication aide (MA) on 07/29/25 at 8:15am and 12:45pm revealed:
-He served the residents eggs, sausage, grits, coffee and water for breakfast that morning, 07/29/25.
-He had not seen live bugs in the grits when he prepared them for breakfast.
-He would not have served the grits, and he would have thrown them away if he had seen live bugs.
-He checked the beans before he cooked and served them for lunch; he did not see bugs in the beans.
-He had not seen any bugs in the food or the kitchen cabinets before.

Interviews with the Administrator on 07/29/25 at 9:00am and 10:10am revealed:
-She locked the lids to the totes because she did not want the staff to eat all the food.
-The pest control company had been treating the facility for bugs for about a year.

Telephone interview with the Administrator on 07/31/25 at 8:56am revealed:
-She had instructed the MA to throw the food with

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C 257	Continued From page 59 the bug in it away when it was found on Tuesday, 07/29/25. -The MA threw away two bags of beans with a hole in them, and the boxes of macaroni and cheese; he dumped the grits and oatmeal out. -The MA cleaned off the canned food and the bin. -There were other lentils in the storage room in a basket, and the MA served them. -The MA should not have served the grits; he should have noticed the bugs in the food and in the storage area. -The bug in the kitchen was a new problem; she had not had a problem with them before this week. Attempted telephone interview with inspector for the local Environmental Health Department on 07/29/25 at 2:42pm was unsuccessful. _____ The facility failed to ensure all food items stored in the facility were protected from contamination related to live bugs in a storage bin containing bags of dried beans that were prepared and served to residents for lunch on 07/29/25, and live bugs in food storage containers in the kitchen including dried grits that were prepared and served to the residents for breakfast on 07/29/25. This failure was detrimental to the health, safety, and the welfare of the residing in the facility and constitutes a Type B Violation. _____ The facility failed to provide a plan of protection in accordance with G.S. 131D-34 on 07/31/25 for this violation. A SUMMARY SUSPENSION OF LICENSE WAS ISSUED ON JULY 31, 2025.	C 257		

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C 266	Continued From page 60	C 266		
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 substituted and served to the residents. The findings are: Observation of the lunch meal on 07/29/25 from 1:55am to 12:12pm revealed: -There were five residents; three residents from the sister facility and two residents from 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.	C 266		

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C 266	Continued From page 61 -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 substitution log was handwritten with hand drawn columns and boxes. -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. Review of the facility's substitution log on 07/30/25 at 8:07am revealed there were no other items documented as substitutions for 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:	C 266		

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C 266	Continued From page 62 -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) on 07/29/25 at 8:15am revealed: -The residents from the sister facility next door came over and ate lunch and dinner with the residents at this facility. -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. -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 fix from what he had. -He documented the meal substitutions on the	C 266		

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substitution sheet.
-He did not realize there were no vegetables in the meal he served.
-He did not realize French fries were not a vegetable.
-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.
-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; 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

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C 266	Continued From page 64 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 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 seen; it had been over two weeks.	C 266		
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 A2 VIOLATION Based on observations and interviews, the facility failed to ensure each resident was treated with respect and dignity as evidenced by residents who were bitten by bed bugs and could not sleep at night because the live bed bugs were biting them; and the residents who resided in the facility had to go to the sister facility when the facility did	C 311		

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C 311	Continued From page 65 not have staff or when the facility was sprayed for bed bugs. The findings are: 1. Review of information about bed bugs from the Centers for Disease Control (CDC) dated 04/26/24 revealed: -When a bed bug bites, it injects fluids that prevent a person from feeling the bite when it happens. -Bed bug bites may not be felt for up to 14 days after being bitten. -Bed bug bites could cause irritation, itching, loss of sleep and allergic reactions; serious allergic reactions could happen including swelling at the sight of the bite and anaphylaxis. -Symptoms of bed bug bites include intense itching which could lead to excessive scratching and possibly a secondary skin infection. -Other symptoms of bed bug bites include insomnia, anxiety and other skin problems from scratching. -Signs of bed bug bites included small bite marks or no physical signs at all. -The easiest way to identify an infestation of bed bugs would be to look for bite marks on the face, neck, arms, hands or any other body parts after sleeping; bite marks could be in a row. -Blood marks on sheets would also be an indication of being bitten by bed bugs. Observation of the resident who resided in resident room #3 on 07/29/25 at 9:30am revealed there were multiple red bumps and whelps on his upper arms; some of the bites were in a row. Interview with the resident who resided in room #3 on 07/29/25 at 9:30am revealed: -He squished bed bugs on the wall at night to kill	C 311		

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them.
-He had live bed bugs in his bed and on him at night while he tried to sleep.
-He had bed bug bites on his arms.
-He tried not to scratch his arms because he did not want them to bleed or make a scar.
-He could not sleep at night because the bed bugs were in his bed, and the bed bugs were biting him.
-Sometimes he left the overhead light on at night because he felt like the bed bugs did not bite him as much with the light on.
-He slept better with the overhead light off, but he was not sleeping anyway because of the bed bugs biting him.
-He felt like he was fighting a war against bed bugs at night.
-He would like to live without the bed bugs because it was so aggravating.
-The bed bugs had been in his room and in his bed for over a year.
-He no longer complained to the Administrator because she saw the bed bugs and knew they were in his room.

Observation of resident room #1 on 07/29/25 at 12:30pm revealed:
-There were brownish red spots on the pillow and the mattress cover on the bed; the sheets had been removed.
-There were black spots and dead bed bugs in the seams of the mattress cover.
-There were black spots on the headboard of the bed.
-There were black spots, debris, and dead bed bugs on the floor around the legs of the bed and the headboard.

Review of a hospital admission report for the resident who resided in resident room #1 dated

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C 311	Continued From page 67 07/29/25 revealed: -He was admitted to the hospital through the Emergency Department (ED) on 07/29/25. -He was covered with live bed bugs upon arrival and required decontamination with nursing assistance. -He had evidence of bed bug bites. -He had multiple areas of bites throughout his body including his torso, and legs with no confluent erythema (spots of redness that did not merge). Telephone interview with the facility's Licensed Health Professional support (LHPS) nurse on 07/29/25 at 2:05pm revealed: -The residents had not complained about bed bugs to her. -She did not go into the residents' rooms. -She had not been told if there were bed bugs in the facility. -She would be concerned if there were bed bugs in the facility because the residents were likely being bitten by the bed bugs. -If the residents had bed bugs bites, then they would scratch the bites and if their skin or fingernails were dirty, they could get skin infections from scratching. Telephone interview with the pest control technician from the facility's contracted pest control company on 07/30/25 at 8:11am revealed: -If there were blood spots on the residents' bedsheets and pillows then the residents were being bitten by the bed bugs. -Some people felt a bed bug bite and some people did not feel the bite; some people said a bed bug bite was painful. -Bed bugs bites could cause an allergic reaction if a resident was allergic to them and was bitten by one.	C 311		

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C 311	Continued From page 68 -Bed bug bites would cause itching and scratching could lead to infections. Interview with the MA on 07/29/25 at 4:20pm revealed: -The residents had not complained about bed bugs biting them. -He knew there were bed bugs in their beds; he had seen them. -He saw the blood stains on the residents' sheets when he washed them. -He did not know that was a sign the bed bugs had bitten the residents. -If he had known he would have told the Administrator. Telephone interview with the Administrator on 07/31/25 at 1:30pm revealed: -She had just been made aware there were bed bugs back in the facility. -She had not had a chance to ask any of the residents if they had bed bug bites. -If she had known there were bed bugs she would have asked the residents if they had been bitten. -The staff had not reported to her that any of the residents were being bitten by bed bugs. -She did not know why the residents did not complain about the bed bug bites. -She guessed if there were bed bugs in their beds then the residents were bitten too. 2.. Interview with a resident on 07/30/25 at 11:56am revealed: -The residents had to go over to the sister facility located next door about once every two weeks. -They would go to the sister facility when there were no staff in the facility or because it was hot in the facility. -They would go over to the sister facility from 10:00am to 5:00pm or later; sometimes it would	C 311		

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be more than eight hours.
-They would eat lunch and dinner at the sister facility when they were there.
-He did not want to go over to the sister facility because once he was there, he had to sit in a chair in the living room all day.
-He could not stretch out, lay down or get comfortable in the sister facility.
-He did not have a choice; he was told by the staff that he had to go.
-It was aggravating to walk with his walker over the uneven gravel and grass to go over to the other building because there was no sidewalk.
-He preferred to be in the facility he lived in.
-He complained to the staff about having to go to the sister facility; the staff did not say anything to him when he complained.

Interview with the medication aide (MA) on 07/30/25 at 4:01pm revealed:
-The residents only went to the sister facility when the facility was being sprayed for bed bugs.
-He went with the residents to the sister facility.
-They stayed at the facility for about four hours.

Telephone interview with the Administrator on 07/31/25 at 1:30pm revealed:
-The residents from the facility would go to the sister facility next door when the facility was sprayed for bed bugs.
-The residents would also go next door to the sister facility if there was an emergency.
-She could not think of a time when there had been an emergency, and the residents had to go to the sister facility and stay.
-She could not think of a time when there was no staff, and the residents had to go to the sister facility.

_____

The facility failed to ensure the residents were

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C 311	Continued From page 70 treated with dignity and respect, related to residents who were bitten by bed bugs. One resident was transported to the hospital and had multiple bed bugs on him, and a second resident could not sleep because of the bed bugs so he left the light on and could not sleep. This failure put the residents at substantial risk for harm 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 311		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#1 and #3) including medication for memory loss, a prostate medication, and a Vitamin (#1) and a quick-acting insulin and a	C 330		

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C 330	Continued From page 71 long-acting insulin (#3). The findings are: 1. Review of Resident #3's current FL-2 dated 07/03/25 revealed diagnosis diagnoses included bilateral deafness, hypertension and type two diabetes. a. Review of Resident #3's current FL-2 dated 07/03/25 revealed: -There was an order to check finger stick blood sugar (FSBS) four times daily. -There was an order for Novolog 100 units/ml (a rapid-acting insulin used to lower blood sugar levels) three times daily inject per sliding scale (SS); there was no information for the sliding scale. Review of a Resident #3's signed physician's order dated 07/03/25 revealed there was an order for Novolog 100units/ml three times daily inject per SS, when FSBS results 70-150, give 15 units; 151-200, give 20units; 201-250, give 25 units; 251-300, give 30 units. Review of a Resident #3's signed physician's order dated 11/12/24 revealed there was an order for Novolog 100units/ml three times daily inject per SS, when FSBS results 70-150, give 15 units; 151-200, give 20units; 201-250, give 25 units; 251-300, give 30 units. Review of Resident #3's May 2025 medication administration record (MAR) revealed: -There was an entry to check FSBS four times daily before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was documentation FSBS were checked four times daily; the FSBS results were not	C 330		

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C 330	Continued From page 72 documented on the entry. -There was an entry for Novolog 100units/ml inject three times day before eating per SS for reading 70-150, give 15 units; 151-200, give 20units; 201-250, give 25 units; 251-300, give 30 units; notify physician for FSBS over 300, scheduled at 8:00am, 12:00pm, and 5:00pm. -There was documentation Novolog was administered three times daily; the FSBS results were not documented and the units administered were not documented. Review of Resident #3's May 2025 FSBS and SSI log revealed: -There were instructions to check Resident #3's FSBS at breakfast, lunch and dinner; to reference the SS for her Novolog and administer three times a day. -There was documentation Resident #3's FSBS checks were done 93 of 93 opportunities. -There were three documented errors with Resident #3's SSI including: -On 05/07/25, FSBS was 611 and 15 units of SSI were administered; 30 units should have been administered. -On 05/15/25, FSBS was 141 and 20 units of SSI were administered; 15 units should have been administered. -On 05/31/25, FSBS was 250 and 30 units of SSI were administered; 25 units should have been administered. Review of Resident #3's June 2025 MAR revealed: -There was an entry to check FSBS four times daily before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was documentation FSBS were checked four times daily; the FSBS results were not documented on the entry.	C 330		

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C 330	Continued From page 73 -There was an entry for Novolog 100units/ml inject three times day before eating per SS for reading 70-150, give 15 units; 151-200, give 20units; 201-250, give 25 units; 251-300, give 30 units; notify physician for FSBS over 300, scheduled at 8:00am, 12:00pm, and 5:00pm. -There was documentation Novolog was administered three times daily; the FSBS results were not documented and the units administered were not documented. Review of Resident #3's June 2025 FSBS and SSI log revealed: -There were instructions to check Resident #3's FSBS at breakfast, lunch and dinner; to reference the SS for her Novolog and administer three times a day. -There was documentation Resident #3's FSBS checks were done 92 of 93 opportunities from 06/01/25 to 06/30/25. -There were 15 documented errors with Resident #3's SSI. -Examples are as follows: -On 06/13/25, FSBS were 125 and 112 and 25 units of SSI were administered; the SSI order was 15 units. -On 06/13/25, FSBS was 168, 25 units of SSI were administered; 20 units should have been administered. -On 06/14/25, FSBS were 90 and 100, 25 units of SSI were administered; 15 units should have been administered. -On 06/14/25, FSBS was 186, 25 units SSI were administered; 20 units should have been administered. -On 06/17/25, FSBS was 212, 20 units SSI were administered; 25 units should have been administered. -On 06/29/25, FSBS was 249, 30 units SSI were administered; 25 units should have been	C 330		

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C 330	Continued From page 74 administered. -On 06/29/25, FSBS was 183, 30 units SSI were administered; 20 units should have been administered. -On 06/21/25, FSBS were 317 and 310, retake was documented, and no SSI was documented as administered. -On 06/22/25, two SSI administrations were documented; one FSBS was 367, retake was documented, and no SSI administration was documented as administered. Review of Resident #3's July 2025 MAR from 07/01/25 to 07/30/25 revealed: -There was an entry to check FSBS four times daily before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was documentation FSBS were checked four times daily; the FSBS results were not documented on the entry. -There was an entry for Novolog 100units/ml inject three times day before eating per SS for reading 70-150, give 15 units; 151-200, give 20units; 201-250, give 25 units; 251-300, give 30 units; notify physician for FSBS over 300, scheduled at 8:00am, 12:00pm, and 5:00pm. -There was documentation Novolog was administered three times daily; the FSBS results were not documented and the units administered were not documented. Review of Resident #3's July 2025 FSBS and SSI log from 07/01/25 to 07/30/25 revealed: -There were instructions to check Resident #3's FSBS at breakfast, lunch and dinner; to reference the SS for her Novolog and administer three times a day. -There was documentation Resident #3's FSBS checks were done 90 of 90 opportunities from 07/01/25 to 07/30/25.	C 330		

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C 330	Continued From page 75 -There were 31 documented errors with Resident #3's SSI. -Examples are as follows: -On 07/02/25, FSBS was 107, 25 units SSI were administered; 15 units should have been administered. -On 07/02/25, FSBS was 229, 30 units SSI were administered; 25 units should have been administered. -On 07/04/25, FSBS was 172, 25 units SSI were administered; 20 units should have been administered. -On 07/04/25, FSBS was 234, 30 units SSI were administered; 25 units should have been administered. -On 07/06/25, FSBS was 161, 30 units SSI were administered; 20 units should have been administered. -On 07/06/25, FSBS was 217, 30 units SSI were administered; 25 units should have been administered. -On 07/07/25, FSBS was 179, 25 units SSI were administered; 20 units should have been administered. -On 07/08/25, FSBS was 144, 25 units SSI were administered; 15 units should have been administered. -On 07/09/25, FSBS was 159, 25 units SSI were administered; 20 units should have been administered. -On 07/10/25, FSBS was 165, 25 units SSI were administered; 20 units should have been administered. -On 07/11/25, FSBS was 167, 25 units SSI were administered; 20 units should have been administered. -On 07/11/25, FSBS was 176, 25 units SSI were administered; 20 units should have been administered. -On 07/12/25, FSBS was 142, 25 units SSI were	C 330		

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administered; 15 units should have been administered.
-On 07/12/25, FSBS was 193, 30 units SSI were administered; 20 units should have been administered.
-On 07/13/25, FSBS was 154, 25 units SSI were administered; 20 units should have been administered.
-On 07/14/25, FSBS was 142, 25 units SSI were administered; 15 units should have been administered.
-On 07/14/25, FSBS was 189, 25 units SSI were administered; 20 units should have been administered.
-On 07/28/25, FSBS was 211, 30 units SSI were administered; 25 units should have been administered.
-On 07/29/25, FSBS was 201, 30 units SSI were administered; 25 units should have been administered.
-On 07/29/25, FSBS was 189, 30 units SSI were administered; 20 units should have been administered.
-On 07/29/25, FSBS was 200, 30 units SSI were administered; 20 units should have been administered.
-On 07/30/25, FSBS was 211, 30 units SSI were administered; 25 units should have been administered.

-On 07/30/25, FSBS was 244, 30 units SSI were administered; 25 units should have been administered.

Observation of Resident #3's medication on hand on 07/29/25 at 8:40am revealed:
-A box of five Novolog 100units/mL pens were dispensed on 07/02/25; each pen was 3ml.
-There were two partially used Novolog pens on hand and one unused pen available for

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C 330	Continued From page 77 administration. Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/31/25 at 9:51am revealed: -Resident #3 had a current order for Novolog 100units/ml inject three times day before eating per SS for reading 70-150, give 15 units; 151-200, give 20units; 201-250, give 25 units; 251-300, give 30 units; notify physician for FSBS over 300, scheduled at 8:00am, 12:00pm, and 5:00pm. -One box of Novolog 100units/ml with five pens was dispensed on 01/03/25, 03/05/25, and 07/02/25. -Each Novolog pen was 3ml and should have lasted over a month and were not on a cycle fill. -Novolog was a fast-acting insulin used to control FSBS. -Too much Novolog could cause FSBS to drop quickly and could cause the resident to go into diabetic hypoglycemia. -Too little could cause the FSBS to become elevated and could cause damage to organ systems including eyes and feet. Telephone interview with a certified medical assistant (CMA) at Resident #3's primary care provider's (PCP) office on 07/31/25 at 12:56pm revealed: -Resident #3 had a current order for SSI for Novolog 100units/ml inject three times day before eating per SS for reading 70-150, give 15 units; 151-200, give 20units; 201-250, give 25 units; 251-300, give 30 units; notify physician for FSBS over 300, scheduled at 8:00am, 12:00pm, and 5:00pm. -If Resident #3's NovoLog was administered at a lower dose than the SSI order her FSBS would not come down as needed and it could lead to	C 330		

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C 330	Continued From page 78 kidney issues, blurred vision and swollen feet; outcomes could happen as soon as a week or two. -If Resident #3's Novolog was administered at a higher dose than her SSI order it could cause her FSBS results to go too low and she could experience shakiness, feel lightheaded, sweating, and have blurred vision; she could end up in the hospital. -The facility should contact the PCP's office anytime they realized Resident #3's Novolog was administered incorrectly. -The PCP expected Resident #3's medication orders to be followed. -Resident #3's last HgbA1C (an AIC test is a blood test that reflects the average blood glucose level over the past three months. An AIC level of 5.7 percent is considered normal) was 7.3 in November 2024. Interview with the medication aide (MA) on 07/30/25 at 2:25pm revealed: -Resident #3 had an order for SSI. -He looked at the order on the insulin box and on the MAR too when he administered her insulin. -After he obtained Resident #3's FSBS he used the results to figure out how much insulin he needed to administer. -He did not document FSBS results or the amount of SSI he administered on the MAR; he only initialed the MAR to document the FSBS and administering the insulin. -He documented the FSBS results, and the amount of SSI he administered on Resident #3's FSBS/SSI log four times a day. -He documented the FSBS results on the FSBS/SSI log first; then he adjusted the amount of insulin to administer on the pen based on the chart on the SSI order. -He documented the amount of insulin he	C 330		

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administered on the log after he gave Resident #3 her injection.
-He must have written down the wrong amounts of insulin administered on the FSBS/SSI log if it was not the correct amount according to the SSI.
-He did not realize he had documented so many errors for July 2025; he may have administered Resident #3 too much insulin.
-Resident #3 never complained about feeling sick or jittery.
-He did not know the number but if Resident #3's FSBS results were in the double digits he knew her blood sugar was too low, and he did not administer any insulin.
-He documented a zero on the log when he did not administer any insulin.

Telephone interview with the Administrator on 07/31/25 at 1:17pm revealed:
-Resident #3's FSBS results went up and down.
-When she looked at Resident #3's FSBS/SSI log, the SSI doses looked correct.
-She had not checked the FSBS/SSI logs in the last two or three weeks.
-There were always errors on the FSBS/SSI logs because the MA would write down the wrong number, but she knew they were giving the correct dose.
-Resident #3 would not let the MA give her the wrong amount of Novolog.
-She believed the MA was documenting the wrong amount of Novolog, but they were administering the correct amounts because Resident #3 would be going through a lot more Novolog and staff would need to order it more often.
-She did not know why the MA documented Resident #3's SSI incorrectly so many times in one month.
-She tried to observe the MA do a FSBS and

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEVERLY RUCKER FAMILY CARE HOME #7	6878 NC HWY 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
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administer Resident #3's Novolog once a month.
-She had not observed the FSBS or the SSI administration for two to three weeks.

Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable.

Refer to the telephone interview with the facility's Licensed Health Profesional Support (LHPS) nurse on 07/29/25 at 2:05pm.

b. Review of Resident #3's current FL-2 dated 07/03/25 revealed:
-There was an order to check finger stick blood sugar (FSBS) four times daily; at breakfast, lunch, dinner and at bedtime.
-There was an order for Toujeo (a long-acting insulin used to lower blood sugar levels) 300units/mL inject 64 units at bedtime.

Review of Resident #3's May 2025 medication administration record (MAR) revealed:
-There was an entry to check FSBS four times daily before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm.
-There was documentation FSBS were checked four times daily; the FSBS results were not documented on the entry.
-There was an entry for Toujeo 300 units/mL inject 64 units at bedtime scheduled at 8:00pm; there was no order to hold the Toujeo for low FSBS.
-Toujeo was documented as administered 31 of 31 opportunities from 05/01/25 to 05/30/25.

Review of Resident #3's May 2025 FSBS/SSI log revealed:
-There were instructions to check Resident #3's FSBS at breakfast, lunch and dinner and bedtime

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C 330	Continued From page 81 and to administer 64 units of Toujeo at bedtime. -There was documentation Resident #3's FSBS checks were done 93 of 93 opportunities from 05/01/25 to 05/31/25. -Resident #3's Toujeo was documented as administered 31 of 31 opportunities from 05/01/25 to 05/31/25. Review of Resident #3's June 2025 MAR revealed: -There was an entry to check FSBS four times daily before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was documentation FSBS were checked four times daily; the FSBS results were not documented on the entry. -There was an entry for Toujeo 300 units/mL inject 64 units at bedtime scheduled at 8:00pm; there was no order to hold the Toujeo for low FSBS. -Toujeo was documented as administered 30 of 30 opportunities from 06/01/25 to 06/30/25. Review of Resident #3's June 2025 FSBS/SSI log revealed: -There were instructions to check Resident #3's FSBS at breakfast, lunch and dinner and bedtime and to administer 64 units of Toujeo at bedtime. -There was documentation Resident #3's FSBS checks were done 90 of 90 opportunities from 06/01/25 to 06/30/25. -Resident #3's Toujeo was held and not administered 2 of 30 opportunities from 06/01/25 to 06/30/25. -Resident #3 refused her Toujeo injection on 06/06/25. -On 06/10/25, FSBS was 65; Resident #3's Toujeo injection was held. -On 06/23/25, FSBS was 69; Resident #3's Toujeo injection was held.	C 330		

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C 330	Continued From page 82 Review of Resident #3's July 2025 MAR from 07/01/25 to 07/29/25 revealed: -There was an entry to check FSBS four times daily before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm and 8:00pm. -There was documentation FSBS were checked four times daily; the FSBS results were not documented on the entry. -There was an entry for Toujeo 300 units/mL inject 64 units at bedtime scheduled at 8:00pm; there was no order to hold the Toujeo for low FSBS. -Toujeo was documented as administered 28 of 28 opportunities from 07/01/25 to 07/29/25. Review of Resident #3's July 2025 FSBS/SSI log from 07/01/25 to 07/29/25 revealed: -There were instructions to check Resident #3's FSBS at breakfast, lunch and dinner and bedtime and to administer 64 units of Toujeo at bedtime. -There was documentation Resident #3's FSBS checks were done 86 of 86 opportunities from 07/01/25 to 07/29/25. -Resident #3's Toujeo was held and not administered 2 of 28 opportunities from 07/01/25 to 07/28/25. -On 07/03/25, FSBS was 158; Resident #3's Toujeo injection was held. -On 07/07/25, FSBS was 87; Resident #3's Toujeo injection was held. Observation of Resident #3's medication on hand on 07/29/25 at 8:40am revealed: -A box with three Toujeo 300units/ml pens were dispensed on 07/03/25. -There was one unused Toujeo pen and one partially used pen available for administration. Telephone interview with pharmacist from the	C 330		

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facility's contracted pharmacy on 07/31/25 at 9:51am revealed:
-Resident #3 had a current order for Toujeo 64 units inject once daily at bedtime.
-There were no parameters and no hold orders for Resident #3's Toujeo.
-Toujeo was a slow long-acting insulin used to keep FSBS consistent over a longer period of time.
-One box of Toujeo had three pens and were dispensed on 05/13/25, 06/17/25, 07/02/25.
-One box of Toujeo should last 22 days; one pen would last a little over a week.
-Toujeo was not on cycle fill and needed to be requested for a refill.

Telephone interview with a CMA at Resident #3's PCP's office on 07/31/25 at 12:56pm revealed:
-Resident #3's Toujeo injection order was for every evening; it was a long-acting insulin and would keep her FSBS level through the night.
-If she skipped her Toujeo injection her FSBS levels could continue to increase overnight, and she would wake up with higher FSBS.
-Resident #3 did not have an order to hold her Toujeo injection for low FSBS.
-Resident #3's Toujeo injection should never be skipped.
-The PCP expected Resident #3's medication orders to be followed.
-Resident #3's last HgbA1C was 7.3 in November 2024.

Interview with the MA on 07/30/25 at 2:25pm revealed:
-Resident #3 had an order for Toujeo at bedtime and FSBS four times a day.
-He looked at the order on the insulin box and on the MAR when he administered her insulin.
-He documented the amount Toujeo 64 units on

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the FSBS/SSI log after he gave Resident #3 her injection.
-He did not know the number but if Resident #3's FSBS results were in the double digits he knew her blood sugar was too low, and he did not administer any insulin.
-He documented a zero on the log under the in amount of insulin administered.
-He had not administered Resident #3's Toujeo when her FSBS results were in the double digits.
-He thought the hold order for Resident #3's low FSBS results was for all of her insulin injections.

Telephone interview with the Administrator on 07/31/25 at 1:17pm revealed:
-Resident #3's FSBS results went up and down.
-The MA was not supposed to hold Resident #3's Toujeo injections for low FSBS results.
-The Toujeo was not part of the SSI order and did not have parameters.
-She was not aware staff was holding Resident #3's Toujeo injections for low FSBS results.

Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable.

Refer to the telephone interview with the facility's LHPS nurse on 07/29/25 at 2:05pm.

2.Review of Resident #1's current FL-2 dated 04/24/25 revealed diagnoses included metabolic encephalopathy, chronic kidney disease, and dementia.

a. Review of Resident #1's current FL-2 dated 04/24/25 revealed there was an order for Vitamin D (used to treat Vitamin deficiency) 1000iu take three tablets once daily.

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C 330	Continued From page 85 Review of Resident #1's June 2025 medication administration record (MAR) revealed: -There was an entry for Vitamin D3 1000iu take three tablets once daily scheduled at 8:00am. -Resident #3's Vitamin D3 was documented as administered 30 of 30 opportunities from 06/01/25 to 06/30/25. Review of Resident #1's July 2025 MAR from 07/01/25 to 07/29/25 revealed: -There was an entry for Vitamin D3 1000iu take three tablets once daily scheduled at 8:00am. -Resident #1's Vitamin D3 was documented as administered 29 of 29 opportunities from 07/01/25 to 07/29/25. Observation of Resident #1's medication on hand on 07/29/25 at 8:38am and 07/30/25 at 2:00pm revealed there was no Vitamin D3 available for administration. Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/31/25 at 9:51am revealed: -Resident #1 had a current order for Vitamin D31000iu take 3 tablets once daily scheduled at 8:00am -Resident #1's three Vitamin D3 tablets were packed in the same multidose package with two other medications for the scheduled 8:00am administration. -Ninety tablets of Vitamin D3 were dispensed on 05/21/25, 06/24/25 and 07/23/25. -Vitamin D3 was a supplement ordered when Vitamin D levels were low. Interview with the MA on 07/30/25 at 4:20pm revealed: -He could not find a medication card for Resident #1 with his Vitamin D3.	C 330		

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C 330	Continued From page 86 -It might have been discontinued. -If he documented it as administered it was a mistake because the medication was not in the medication cart. -He did not know how long Resident #1 did not have his Vitamin D3. Attempted telephone interview with Resident #1's primary care provider (PCP) on 07/29/25 at 2:50pm was unsuccessful. Based on observations, interviews and record reviews Resident #1 was not interviewable. Refer to the telephone interview with the facility's Licensed Health Profesional Support (LHPS) nurse on 07/29/25 at 2:05pm. b. Review of Resident #1's current FL-2 dated 04/24/25 revealed there was an order for memantine (used to treat dementia) 10mg twice daily. Review of Resident #1's June 2025 MAR revealed: -There was an entry for memantine 10mg twice daily scheduled at 8:00am and 8:00pm. -Resident #1's memantine was documented as administered 60 of 60 opportunities from 06/01/25 to 06/30/25. Review of Resident #1's July 2025 MAR from 07/01/25 to 07/29/25 revealed: -There was an entry for memantine 10mg twice daily scheduled at 8:00am and 8:00pm. -Resident #1's memantine was documented as administered 58 of 58 opportunities from 07/01/25 to 07/29/25. Observation of Resident #1's medication on hand	C 330		

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C 330	Continued From page 87 on 07/29/25 at 8:38am and 07/30/25 at 2:00pm revealed: -Resident #1's medication was packaged by scheduled administration times in multidose packages. -There was a multidose package of medication scheduled at 8:00pm; there was a memantine 10mg tablet in the multidose package. -Thirty tablets of memantine 10mg were dispensed in the 8:00pm multidose package; there were 23 tablets available for the morning administration. -There was no multidose or single dose package of memantine scheduled at 8:00am available for administration. Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/31/25 at 9:51am revealed: -Resident #1 had a current order for memantine 10mg twice daily scheduled at 8:00am and 8:00pm. -Resident #1's scheduled 8:00am dose of memantine was packed in the same multidose package with two other medications. -Thirty tablets of memantine 10mg were dispensed in a multidose pack for 8:00am administration on 05/21/25, 06/24/25 and 07/23/25. -Memantine was ordered for memory loss. Interview with the medication aide (MA) on 07/30/25 at 4:20pm revealed: -He could not find a medication card for Resident #1 with his evening dose of memantine. -It might have been discontinued. -If he documented it as administered it was a mistake because the medication was not in the medication cart. -He did not know how long Resident #1 did not	C 330		

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C 330	Continued From page 88 have his memantine. Attempted telephone interview with Resident #1's PCP on 07/29/25 at 2:50pm was unsuccessful. Based on observations, interviews and record reviews Resident #1 was not interviewable. Refer to the telephone interview with the facility's LHPS nurse on 07/29/25 at 2:05pm. c. Review of Resident #1's signed physician's order dated 04/24/25 revealed there was an order for tamsulosin (used to treat enlarged prostate) 0.4mg once daily. Review of Resident #1's June 2025 MAR revealed: -There was an entry for tamsulosin 0.4mg once daily scheduled at 8:00am. -Resident #1's tamsulosin was documented as administered 30 of 30 opportunities from 06/01/25 to 06/30/25. Review of Resident #1's July 2025 MAR from 07/01/25 to 07/29/25 revealed: -There was an entry for tamsulosin 0.4mg once daily scheduled at 8:00am. -Resident #1's tamsulosin was documented as administered 29 of 29 opportunities from 07/01/25 to 07/29/25. Observation of Resident #1's medication on hand on 07/29/25 at 8:38am and 07/30/25 at 2:00pm revealed there was no tamsulosin available for administration. Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/31/25 at 9:51am revealed:	C 330		

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C 330	Continued From page 89 -Resident #1 had a current order for tamsulosin 0.4mg daily scheduled at 8:00am. -Resident #1's scheduled 8:00am dose of tamsulosin was packed in the same multidose package with two other medications. -Thirty tablets of tamsulosin were dispensed in a multidose pack for 8:00am administration on 05/21/25, 06/24/25 and 07/23/25. -Tamsulosin was ordered to improve bladder retention. Interview with the MA on 07/30/25 at 4:20pm revealed: -He could not find a medication card for Resident #1 with his tamsulosin. -It might have been discontinued. -If he documented it as administered it was a mistake because the medication was not in the medication cart. -He did not know how long Resident #1 did not have his tamsulosin. Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/31/25 at 9:51am revealed: -Resident #1's had three medications dispensed in the same multidose package for scheduled 8:00am administration. -The medications were on cycle fill. -Each multidose bubble had the date to administer and the list of medications on the back of the bubble. Telephone interview with the Administrator on 07/31/25 at 1:30pm revealed: -She was not aware Resident #1 did not have some of his medications. -The MA needed to find out where they went. -The MA should have noticed there were missing medications.	C 330		

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C 330	Continued From page 90 -She had no answer for why the medications for Resident #1 were not in the medication cart. -The missing medications were on a cycle fill. -If the three medications were in the same multidose card then the card should have been in the medication cart; medications were only stored on the medication cart. Attempted telephone interview with Resident #1's PCP on 07/29/25 at 2:50pm was unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. Refer to the telephone interview with the facility's LHPS nurse on 07/29/25 at 2:05pm. _____ Telephone interview with the facility's LHPS nurse on 07/29/25 at 2:05pm revealed: -She had visited the facility recently and the residents' MARs were not in the facility to review. -When she requested them, she was told the Administrator had them. -She could not follow if medications were being administered correctly without the MARs. -She questioned the staff on how they knew what to administer without the MAR to reference. -Staff told her they knew what to give to the residents. _____ The facility failed to ensure medications were administered as prescribed to two residents The incorrect amounts of a quick acting insulin were administered on multiple occasions and doses of a long-acting insulin were held on four occasions putting the resident at risk for elevated blood sugar levels or low blood sugar levels (#3). The resident's FSBS ranged from 63 to 611 and Resident #3's HgbA1C was 7.3 in November	C 330		

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C 330	Continued From page 91 2024. This failure put the residents at substantial risk for harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/29/25.	C 330		
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: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure residents were observed taking their medications, medications were documented immediately after administration by the staff who prepared and administered the medications to 2 of 2 residents (#1 and #2) who took the wrong medications. The findings are: Observation of the facility on 07/29/25 at 8:16am revealed the residents' medication administration records (MAR) were not in the facility.	C 341		

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C 341	Continued From page 92 Observation of the facility on 07/29/25 at 8:45am revealed: -The Administrator arrived at the facility with the residents' MARs. -The residents' MARs were kept together in a binder. 1. Review of Resident #1's current FL-2 on 04/24/25 revealed: -Diagnoses included metabolic encephalopathy, chronic kidney disease, and dementia. -There was an order for vitamin D (used to treat vitamin deficiency) 1000iu take three tablets once daily. -There was an order for memantine (used to treat dementia) 10mg twice daily. -There was an order for finasteride (used to treat enlarged prostrate) 5mg once daily. -There was an order for amlodipine (used to treat high blood pressure) 2.5mg once daily. -There was an order for cetirizine (used to treat allergy symptoms) 5mg once daily. -There was an order for donepezil (used to treat Alzheimer's disease) 5mg once daily. -There was an order for ezetimibe (used to lower cholesterol) 10mg once daily. -There was an order for aspirin (used to prevent heart disease) 81mg once daily. -There was an entry for levetiracetam (used to treat seizures) 50mg twice daily scheduled at 8:00am and 8:00pm. Review of Resident #1's signed physician's order dated 04/24/25 revealed there was an order for tamsulosin (used to treat enlarged prostrate) 0.4mg once daily. Review of Resident #1's MAR on 07/29/25 at 9:50am revealed:	C 341		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEVERLY RUCKER FAMILY CARE HOME #7	6878 NC HWY 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 341	Continued From page 93 -There was documentation of administration of medications at 8:00pm on 07/28/25, and 8:00am on 07/29/25. -The initial indicated another medication aide (MA) had initialed the MAR and not the MA who had administered the medications the night before and that morning. Observation of Resident #1 on 07/29/25 at 9:10am revealed: -He was sitting in a chair in the living room. -He had slid down into the chair and the lower portion of his back was resting on the cushion seat of the chair. -He was leaning to his left side. -He was speaking, but his speech was slurred. -He was shouting, calling names and was agitated. -The resident complained about not feeling well to the Administrator and the medication aide (MA). -He told the MA that he gave him the wrong medications. -He was holding his eyeglasses in his hand. -At 9:25am, the MA took Resident #1's blood pressure and documented it as 144/92. -The Administrator asked Resident #1 if he wanted to go to hospital and he said yes. -The Administrator had the MA call 911 to transport the resident. Interview with Resident #1 on 07/29/25 at 9:10am revealed: -He did not feel right, he was numb all over parts of his body. -His legs were numb. -He did not usually feel like this. -He felt good this morning and ate breakfast. -He did not feel bad until after he took his medications. -The MA gave him the wrong medications.	C 341		

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C 341	Continued From page 94 -He knew he got the wrong medications because he had never been numb after taking his medications. -He did not know what his medications were. -His medications were in a cup on the table when he took them. -His legs were numb, and he did not think he could walk on his own. -He could no longer hold his eyeglasses and asked if someone could hold them for him. Observation of Resident #1 on 07/29/25 at 9:50am revealed: -The resident told the emergency medical technician (EMT) he was given the wrong medications. -The MA told the EMT Resident #1 might have taken another resident's morning medications when he looked away. -The local emergency EMT took Resident #1's blood pressure, it was 140/98. -Resident #1 was transported by the EMT to the local emergency department (ED) for evaluation. Telephone interview with Resident #1's power of attorney (POA) on 07/29/25 at 2:49pm revealed: -Resident #1 could tell you if something was wrong or he did not feel good. -The facility staff had called her that morning to tell her Resident #1 was being sent to the hospital because he took the wrong medications. -If Resident #1 saw medications in a cup on a table he would assume they were his and he would take them. -He would not recognize his medications, or if the medications were another residents medications. -Resident #1 would ask questions if he thought something was wrong or not right. -She was concerned about how the facility was administering his medications because his	C 341		

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C 341	Continued From page 95	C 341		

memory was not good anymore.
-He was not taking his medications when he was living alone.
-One of the reasons he was in the facility was so they would administer his medications to him.
-He could not stand to walk and had difficulty walking since his stroke.
-He had vascular dementia from a prior stroke.
-He would say his legs were not strong enough to walk.

Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/31/25 at 9:51am revealed:
-Resident #1 had a levetiracetam that was ordered to help prevent seizures.
-One missed dose might be okay but should be taken as soon as the resident realized it was missed if it was close to the missed scheduled time.
-The physician should be contacted to let them know there was a missed dose; they should not miss more doses.
-Resident #1 had blood pressures medications that if mistakenly taken by another resident they could lower their blood pressure.
-The resident could become dizzy and fall; the resident's physician should be notified if they took another resident's medications or the facility could call the pharmacy to ask questions.

Telephone interview with the facility's Licensed Health Professional Support (LHPS) nurse on 07/29/25 at 2:05pm revealed:
-Resident #1 was forgetful but he was alert and oriented times four.
-He would be able to communicate his symptoms but may not know his medications.

Interviews with the MA on 07/29/25 at 9:50am

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C 341	Continued From page 96 and 11:31am revealed: -He did not see Resident #1 take his medications. -He thought Resident #1 took another resident's medication because the other resident was seated beside him and the medication cups were next to each other. Interview with the MA on 07/30/25 at 4:01pm revealed: -Yesterday, 07/29/25, he placed Resident #1's medications on the right side of his plate and the other resident's medications on the left side of her plate; that was how he mixed up their medications. -He thought both residents knew their medications and would not get them mixed up. -One evening Resident #1 pointed out that his morning medications were in the cup; the resident knew it was the wrong time of the day. Interviews with the Administrator on 07/29/25 at 9:10am, and 10:00am revealed: -Resident #1 was not usually agitated and did not call names or shout. -This was not like him. -Resident #1 sat slumped in his chair every day. -Resident #1 would get weak and agitated every six to eight months. -He would get admitted to the hospital and stay for about two weeks. -She could not remember the last time it had happened; "it had been a good bit of time ago, maybe a year". -The last time he had returned from the hospital with a diagnosis of seizures. Review of Resident #1's hospital admission record dated 07/29/25 revealed: -After he arrived at the ED he was admitted to the hospital's intensive care unit (ICU).	C 341		

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C 341	Continued From page 97 -It was reported from the facility that he had possibly taken another resident's medications. -He was minimally interactive, occasional single word responses such as "no". -There were concerns of an infection versus a possible stroke. -He was admitted for concerns of hypothermia, his temperature was 95.4 degrees Fahrenheit, a change in his mental status and somnolence (excessive sleepiness) and possible encephalopathy. Attempted telephone interview with Resident #1's primary care provider (PCP) on 07/29/25 at 2:50pm was unsuccessful. Refer to the telephone interview with the facility's LHPS nurse on 07/29/25 at 2:05pm. Refer to the interview with a resident on 07/30/25 at 11:56am. Refer to the interview with the MA on 07/29/25 at 8:05am. Refer to the second and third interviews with the MA on 07/29/25 at 9:50am and 11:31am. Refer to the interview with the MA on 07/30/25 at 4:01pm. Refer to the interviews with the Administrator on 07/29/25 at 9:10am, and 10:00am. Refer to the third interview with the Administrator on 07/29/25 at 12:10pm. Refer to the telephone interview with the Administrator on 07/31/25 at 1:30pm.	C 341		

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C 341	Continued From page 98 2. Review of Resident #3's current FL-2 dated 07/03/25 revealed: -Diagnosis diagnoses included bilateral deafness, hypertension and type two diabetes. -There was an order for benztropine (used to treat Parkinson's disease) 1mg once daily. -There was an order for metformin (used to treat type 2 diabetes) 1000mg in the morning. -There was an order for lisinopril (used to treat high blood pressure) 5mg once daily. -There was an order for simvastatin (used to treat high cholesterol) 40mg in the morning. -There was an order for sertraline (used to treat depression) 1000mg after breakfast. -There was an order for montelukast (used to prevent asthma attacks) 10mg once daily. -There was an order for clozapine (used to treat schizophrenia) 150mg twice daily. -There was an order for lithium (used to treat bipolar disorder) 450mg at bedtime. Review of Resident #3's medication administration record (MAR) on 07/29/25 at 9:50am revealed: -There was documentation of administration of medications at 8:00pm on 07/28/25, and 8:00am on 07/29/25. -The initial indicated another medication aide (MA) had initialed the MAR and not the MA that had administered the medications the night before and that morning. Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/31/25 at 9:51am revealed: -Clozapine was ordered to treat schizophrenia. -Resident #3 had an order for clozapine 150mg. -If another resident mistakenly took Resident #3's mediation she would be concerned about the resident taking the clozapine.	C 341		

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C 341	Continued From page 99 -Clozapine was started at low doses, typically at 25mg, and gradually increased over a period of time because it could cause cardiac issues if suddenly introduced at a high dose. -Taking a dose of 150mg of clozapine without a gradual dose increase could cause a heart attack, prolonged QT intervals in the heart (measurement of the time taken for the heart's ventricles to contract and relax before the next beat; long or short QT intervals could indicate a risk of dangerous heart rhythm problems), arrythmia, stroke, or hypotension. -If someone mistakenly took 150mg of clozapine without the gradual dose increase they would need to notify their physician right away or go to the hospital if they started to have symptoms. -If a resident missed a single dose of clozapine, they would not notice any symptoms because clozapine stayed in the body for 12 hours; they would still have some in their system from the dose the night before. Attempted telephone interview with Resident #3's mental health provider (MHP) on 07/31/25 at 11:11am was unsuccessful. Refer to the telephone interview with the facility's Licensed Health Professional Support (LHPS) nurse on 07/29/25 at 2:05pm. Refer to the interview with a resident on 07/30/25 at 11:56am. Refer to the interview with the MA on 07/29/25 at 8:05am. Refer to the second and third interviews with the MA on 07/29/25 at 9:50am and 11:31am. Refer to the interview with the MA on 07/30/25 at	C 341		

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C 341	Continued From page 100 4:01pm. Refer to the interviews with the Administrator on 07/29/25 at 9:10am, and 10:00am. Refer to the third interview with the Administrator on 07/29/25 at 12:10pm. Refer to the telephone interview with the Administrator on 07/31/25 at 1:30pm. _____ Telephone interview with the facility's LHPS nurse on 07/29/25 at 2:05pm revealed: -She had visited the facility recently and the residents' MARs were not in the facility to review. -When she requested them, she was told the Administrator had them. -She could not follow if medications were being administered correctly without the MARs. -She questioned the staff on how they knew what to administer without the MAR to reference. -Staff told her they knew what to give to the residents. Interview with a resident on 07/30/25 at 11:56am revealed: -The MA placed the residents' medications cups on the table before the residents were seated at the table for breakfast. -The medication cups did not have names on them. -The medication cups were not always put on the table at the same place every day. -He was worried about getting other residents' medications mixed up with his, so he always looked at his medications before he took them. -He knew what medications he took. -The MA did not watch the residents take their medications; they took them whenever and at different times during the meal.	C 341		

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C 341	Continued From page 101 -Usually, the medication cups were on the right side of his plate but sometimes they were not. -About a week ago a resident picked up another resident's medication cup and recognized it was not her medication. -The resident told the MA, and the MA switched the medication cups before the residents took the wrong medication. -The resident got upset when she saw the wrong medication in her cup. Interview with the MA on 07/29/25 at 8:05am revealed: -He had administered medications to the residents the day before, 07/28/25, and today, 07/29/25. -The residents' MAR records for the facility were kept together in one book. -The MAR book was not in the facility because the Administrator took it the day before, 07/28/25, because a resident had a physician's appointment. -He did not have the MARs to reference or document the administration of the evening medications the night before, 07/28/25. -He did not have the MAR to reference or document the administration of the morning medications on 07/29/25. -He used the label on the medications as a guide when he administered the medications without the MAR. -He called the Administrator when he administered the residents' medications on 07/28/25 and 07/29/25 to tell her he was done. -The Administrator documented the administration of the medications to the residents on the evening of 07/28/25 and that morning, 07/29/25. -He put the medications into cups and gave them to the residents.	C 341		

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C 341	Continued From page 102 Second and third interviews with the MA on 07/29/25 at 9:50am and 11:31am revealed: -His initial on the MAR was the first letter of his first name and the other MA initialed with the first letter of their first name. -He had not initialed the MARs last night 07/28/25, or that morning, 07/29/25, because he did not have the residents' MARs. -He did not monitor the residents taking their medications that morning, 07/29/25. -He placed the residents' medications in individual cups and set them on the table. -He turned away to do something else and he took his eyes off the residents and the medications. Interview with the MA on 07/30/25 at 4:01pm revealed: -He always placed the medications in cups at the residents' place settings. -He never prompted the residents to take their medications, and he never watched them take their medications either. -He documented on all the residents' MARs after breakfast, after all the residents had taken their medication. -This morning, 07/30/25, before the residents came to breakfast, he placed the residents' medications in a cup and set them at their place settings. -This morning, he watched them take their medications at the same time. -They had never taken each other's medications before. -He knew he was supposed to have the residents come to the medication cart one at a time, punch the medication out of the cards one at a time, watch them take them one at a time and document on the MAR right after they took them.	C 341		

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C 341	Continued From page 103 -He did the medication pass the same way every day. Interviews with the Administrator on 07/29/25 at 9:10am, and 10:00am revealed: -She had taken the book with the residents' MARs out of the facility that morning, 07/29/25, to make copies of one of the resident's MAR because they had a physician's appointment later that day. -The MA had already administered the residents their medications and had already signed on the MAR when she picked it up; she did not recall the time. Third interview with the Administrator on 07/29/25 at 12:10pm revealed: -The MA was supposed to sign the MAR after he administered each resident their medication. -The MA told her he administered the medications the night before, 07/28/25. -The MA called her that morning after she had picked up the book with the MARs again and told her the state survey team was at the facility. -The MA had not signed the MARs when he administered medications the night before, 07/28/25. -She noticed he had not documented on the MAR, so she documented that morning, 07/29/25. -She initialed it for him, and she wrote the wrong MA's initials. -The MA should have documented on the MAR when he administered the medications. -She had trainings and told the MAs when to document on the MAR and to watch the residents. -The MAs knew they were not allowed to put the medication cups on the table for the residents to take.	C 341		

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C 341	Continued From page 104 -The MAs were supposed to watch the resident take their medication and then watch the next resident take theirs. -The medication cups should never have been placed on the table. Telephone interview with the Administrator on 07/31/25 at 1:30pm revealed: -She did not have a policy or procedure for the MAs to follow when a resident got the wrong medication. -The MA did not tell her the residents' medications had been mixed up before. _____ The facility failed to administer residents' medications individually, to watch them take their medications and document on the MAR immediately after each administration for two residents when there were no MARs in the facility. The medications were placed into cups and sat on a table; the residents got the cups mixed up without the MA watching them and took the wrong medications. Resident #1 had numbness in his legs, overall weakness and slurred speech, and due to the way he was feeling he requested to be transported to the hospital because he knew he was administered the wrong medication. This failure resulted in serious physical harm and neglect which constitutes an 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 341		