DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on October 5, 2022.	C 000		
C 202	10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure upon admission tuberculosis testing was completed for 2 of 3 sampled residents (#1 and #2) in compliance with the control measures adopted by the Commission for Public Health. The findings are: 1. Review of Resident #1's current FL-2 dated 04/25/22 revealed diagnoses included cognitive neuro-behaviors, dementia, diabetes mellitus, hypercholesteremia, and intellectual disability. Review of Resident #1's record revealed: -There was a tuberculosis (TB) skin test given on	C 202	Administrator will assure any new resident that comes into facality will have A 2 step TB test also will be Read sign and dated by doctor or nurse. 11-28-22	

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE — TITLE — DATE

Lisa Boggs — Administrator — 11/28/22

Reviewed and acknowledged- SS- 12/05/22

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 202	Continued From page 1 02/13/21 and read as negative on 02/14/21. -There was a document with several dates for TB skin test given, but no read dates with results. -The document did not include documentation of who gave the TB skin test. Interview with Resident #1 on 10/05/22 at 3:27pm revealed: -He had a TB skin test previously, but he did not know the results. -He did not know when he had a TB skin test. Refer to the interview with the Administrator on 10/05/22 at 4:15pm. 2. Review of Resident #2's current FL-2 dated 12/01/21 revealed diagnoses included bipolar disorder, intellectual disability, attention deficit disorder, seizure, allergic rhinitis, asthma, and chronic obstructive pulmonary disorder. Review of Resident #2's record revealed there was no documentation of any tuberculosis (TB) skin tests. Interview with Resident #2 on 10/05/22 at 6:30pm revealed he had a TB skin test in the past, but he did not know the results. Interview with the Administrator on 10/05/22 at 4:15pm revealed: -She initially thought Resident #2 was admitted with a TB skin test. -Resident #2 was admitted with a chest x-ray.	C 202	Administator will assure that all residents coming into facility will have TB 1 & 2 step reminder by electronic device Alexa	11-28-22

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

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)	COMPLETE DATE
C 202	Continued From page 2 -After admission, a resident would need a second TB skin test. -She was told that she could use a chest x-ray in place of a TB skin test for admission. -She did not know there were residents who were missing TB skin tests. -She was responsible for ensuring residents had TB skin tests upon admission in compliance with the control measures adopted by the Commission for Public Health. Refer to the interview with the Administrator on 10/05/22 at 4:15pm. _____ Interview with the Administrator on 10/05/22 at 4:15pm revealed: -When residents were admitted to the facility, they were admitted with a completed TB skin test. -After admission, a resident would need a second TB skin test. -She was told that she could use a chest x-ray in place of a TB skin test for admission. -She did not know there were residents who were missing TB skin tests. -She was responsible for ensuring residents had TB skin tests upon admission in compliance with the control measures adopted by the Commission for Public Health.	C 202		
C 207	10A NCAC 13G .0702 (c) (4) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 (c) (4) Tuberculosis Test and Medical Examination (c) The results of the complete examination are to be	C 207		

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 207	Continued From page 3 entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (4) If the information on the FL-2 or MR-2 is not clear or is insufficient on the current FL-2 for 1 of 3 sampled residents (#1). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the physician was contacted for clarification of information that was not clear or insufficient on the current FL-2 for 1 of 3 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 04/25/22 revealed: -Diagnoses included cognitive neuro-behaviors, dementia, diabetes mellitus, hypercholesteremia, and intellectual disability. -There was no diet order. -There was a partial order for Lantus Solostar (long acting insulin used to control high blood sugar) without a route and frequency. Review of Resident #1's record revealed there was a previous FL-2 dated 04/08/21 without a diet order. Interview with Resident #1 on 10/05/22 at 3:27pm revealed: -He did not have a special diet.	C 207	Administrator will ASURE that All Medication's ARE CORRECT ORDERS from PCP ON FI-2, CAREplan AND MAR IF ORDER ISNT CLEAR Administrator will CONTACT PCP to Clarify ORDER.. 11-28-22 Adminstrator will make SURE that ANY ORDER for Insulin will have time, dosage FREQUENCY from PCP Also make SURE Glucometer READS CORRECT Also ON MARS 11-28-22	

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 207	Continued From page 4 -He received insulin every day. Interview with a nurse at Resident #1's Primary Care Provider's (PCP) office on 10/05/22 at 2:25pm revealed: -She reviewed Resident #1's documents in the computer system. -There were notes that Resident #1 was encouraged to follow a low carbohydrate diet to prevent blood sugar spikes. -Resident #1's PCP completed his FL-2, but she could not locate the most recent one in the computer system. Interview with the Administrator on 10/05/22 at 4:15pm revealed: -Residents' FL-2s were sometimes completed by the PCP and sometimes she filled in the information for the PCP. -She completed Resident #1's current FL-2 dated 04/25/22 and she did not know a diet order was not on the FL-2. -Usually the resident's PCP, wrote the diet on the FL-2. -She thought Resident #1 was on a no concentrated sweets diet. -She knew that medication orders included the name of the medication, strength, dosage and frequency. -She did not realize that she did not write the frequency and route for Resident #1's Lantus Solostar. -She was responsible for ensuring residents' FL-2s contained all the needed information.	C 207	Administrator will ASURE that all ORDERS ARE CORRECT AND complete ON FI-2 diet, medication RT, AND frequney, dosage. Administrator will have a Reminder IN play using Alexa Electronic deviee.	11-28-22 11-28-22
C 249	10A NCAC 13G .0902 (c) (3-4) Health Care 10A NCAC 13G .0902 (c) (3-4) Health Care	C 249		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 249	Continued From page 5 (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 observations, record reviews, and interviews, the facility failed to implement orders for 2 of 3 sampled residents (#1 and #3) with orders for fingerstick blood sugar monitoring. The findings are: 1. Review of Resident #1's current FL-2 dated 04/25/22 revealed: -Diagnoses included diabetes mellitus, cognitive neuro-behaviors, dementia, hypercholesteremia, and intellectual disability. -There was an order to monitor Resident #1's fingerstick blood sugar (FSBS) twice weekly. Review of Resident #1's September 2022 printed medication administration record (MAR) revealed: -There was an entry for FSBS twice weekly, without a scheduled time. -There was documentation of FSBS twice weekly for the weeks of 09/01//22-09/03/22, 09/11/22-09/17/22, and 09/25/22-09/30/22. -There was no documentation of FSBS twice weekly for the weeks of 09/04/22-09/10/22 and 09/18/22-09/24/22.	C 249	Adminstrator will ASURE that any RESIDENT that has an order FOR Blood sugar finger checks will documented ON MAR Also making sure Reading will be each RESIDENTS file. A reminder will be IN play by USING A ELECTRONIC device ALEXA	11/28/22

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 249	Continued From page 6 Observation of Resident #1's glucometer on 10/05/22 at 5:07pm revealed: -His glucometer was enclosed in a case labeled with his name. -There was a lancet pen and bottle of glucometer strips in the case for Resident #1. -Resident #1's glucometer was operable. Interview with Resident #1 on 10/05/22 at 3:27pm revealed: -He had his FSBS checked by the Administrator, but he did not know how often. -His Primary Care Provider (PCP) told him his FSBS were good. Telephone interview with a representative at Resident #1's PCP's office on 10/05/22 at 2:25pm revealed she found documentation in Resident #1's profile that his FSBS should be done twice weekly. Refer to the interview with the Administrator on 10/05/22 at 4:15pm. 2. Review of Resident #3's current FL-2 dated 04/28/22 revealed diagnoses included schizoaffective disorder bipolar type, and hyperlipidemia. Review of Resident #3's previous FL-2 dated 04/08/21 revealed there was an order for fingerstick blood sugar (FSBS) twice weekly. Review of Resident #3's August 2022, September 2022, and October 2022 printed medication administration	C 249	11-28-22 Administrator will assure that any resident that has an order for Blood Sugar finger checks will be documented on MAR also also will be recorded in residents file A reminder will be in play by using A electronic device ALEXA	

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 249	Continued From page 7 record (MAR) revealed: -There was an entry for FSBS daily and document, without a scheduled time. -There was no documentation of FSBSs for August 2022, September 2022, and October 2022. Observation of Resident #3's glucometer on 10/05/22 at 5:08pm revealed: -His glucometer was enclosed in a case labeled with his name. -There was a lancet pen and bottle of glucometer strips in the case for Resident #3. -Resident #3's glucometer was operable but contained no FSBSs in memory. -No FSBSs appeared on the glucometer screen for the 7 days, 14 days, and 30 days averages. Observation of Resident #3 on 10/05/22 at 5:16pm revealed the Administrator obtained his FSBS and the FSBS reading was 152. Telephone interview with a representative at Resident #3's PCP's office on 10/05/22 at revealed: -She found documentation in Resident #3's profile that his FSBS should be done daily. -She did not think Resident #3's FSBS were brought to the office for the PCP to review. -Staff at the PCP's office usually did a FSBS when Resident #3 came to the office. Interview with the Administrator on 10/05/22 at 4:15pm revealed: -She knew Resident #3's FSBS were supposed to be	C 249	ADMINSTRATOR WILL ASSURE that ANY RESIDENT that HAS AN ORDER FOR blood sugar finger checks will be done AS ORDER FROM PCP AND documented ON MAR Also IN Resident file. Also a REMINDER will be IN play by ELECTRONIC device ALEXA 11-28-22	

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 249	Continued From page 8 daily but when she tested his FSBS it was not high. -She asked Resident #3's PCP to change the frequency of his FSBS to twice weekly. -She did not have any documentation that it was changed to twice weekly. -She did not know why Resident #3's glucometer did not show any FSBS values because she obtained FSBS for him twice weekly. Attempted interview with Resident #3 on 10/05/22 at 3:12pm was unsuccessful. Refer to the interview with the Administrator on 10/05/22 at 4:15pm. Interview with the Administrator on 10/05/22 at 4:15pm revealed: -She obtained FSBSs for residents who had an order for FSBS. -She documented residents' FSBS on the MARs most of the time. -She had a notebook that she wrote Resident #1's FSBS values but not Resident #3. -She did not have a reason for not completing the FSBS as ordered by the PCP. -She was responsible for ensuring orders were implemented for residents.	C 249	11-28-22 Adminstrator will assure FSBS will be done as ordered by PCP also documented on MAR also in Residents file will be reminded by eletronic device ALEXA	
C 254	10A NCAC 13G .0903 (c) Licensed Health Professional Support 10A NCAC 13G .0903 (c) Licensed Health Professional Support	C 254		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 254	Continued From page 9 (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure a Licensed Health Professional Support evaluation was completed initially and quarterly for 2 of 2 sampled residents (#1 and #3) with a LHPS task of fingerstick blood sugar (FSBS) monitoring. The findings are: 1. Review of Resident #1's current FL-2 dated 04/25/22 revealed: -Diagnoses included diabetes mellitus, cognitive neuro-behaviors, dementia, hypercholesteremia, and	C 254	Administrator will A sure that ~~RN~~ LHPS Evaluation will be Asset every Quarter on any resident that requires insulin, FSBS Also by A reminder by A Electronic device Alexa.	11-28-22

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

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)	COMPLETE DATE
C 254	Continued From page 10 intellectual disability. -There was an order to monitor Resident #1's fingerstick blood sugar (FSBS) twice weekly. Review of Resident #1's record revealed there were no LHPS evaluations. Observation of Resident #1 on 10/05/22 at 9:25 am revealed the Administrator administered insulin to Resident #1 in his right arm. Observation of Resident #1's glucometer on 10/05/22 at 5:07pm revealed: -His glucometer was enclosed in a case labeled with his name. -There was a lancet pen and bottle of glucometer strips in the case for Resident #1. -Resident #1's glucometer was operable and contained previous FSBS values. Interview with Resident #1 on 10/05/22 at 3:27pm revealed: -He had FSBS obtained by the Administrator. -He received insulin every day. Refer to the interview with the Administrator on 10/05/22 at 4:15pm. 2. Review of Resident #3's current FL-2 dated 04/28/22 revealed diagnoses included schizoaffective disorder bipolar type, and hyperlipidemia. Review of Resident #3's previous FL-2 dated 04/08/21	C 254		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 254	Continued From page 11 revealed there was an order to monitor fingerstick blood sugar (FSBS) twice weekly. Review of Resident #3's record revealed there were no LHPS evaluations. Observation of Resident #3's glucometer on 10/05/22 at 5:08pm revealed: -His glucometer was enclosed in a case labeled with his name. -There was a lancet pen and bottle of glucometer strips in the case for Resident #3. -Resident #3's glucometer was operable but contained no FSBS values in the memory. -No FSBS values appeared for the 7 days, 14 days, and 30 days averages. Observation of Resident #3 on 10/05/22 at 5:16pm revealed the Administrator obtained his FSBS and the FSBS reading was 152. Attempted interview with Resident #3 on 10/05/22 at 3:12pm was unsuccessful. Refer to the interview with the Administrator on 10/05/22 at 4:15pm. _____ Interview with the Administrator on 10/05/22 at 4:15pm revealed: -She did not have a LHPS nurse to complete LHPS evaluations. -She had not attempted to obtain a LHPS nurse. -She was responsible for ensuring a LHPS nurse was	C 254	Administrator will asure that a LHPS will evaluate resident every quarter also by doing Assetment	11-28-22

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 254	Continued From page 12 available to complete LHPS evaluations for residents who had a LHPS task.	C 254		
C 315	10A NCAC 13G .1002 (a) Medication Orders 10A NCAC 13G .1002 (a) Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure contact with 1 of 3 sampled residents (#1) Primary Care Provider (PCP) for clarification of orders for a long acting insulin. The findings are: Review of Resident #1's current FL-2 dated 04/25/22 revealed: -Diagnoses included cognitive neuro-behaviors, dementia, diabetes mellitus, hypercholesteremia, and intellectual disability. -There was an order for Lantus Solostar (a long acting	C 315	~~Administrator will assure that a LHPS~~ Administrator will assure all orders are complete with PCP by using Electronic device	11-28-22

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 315	Continued From page 13 insulin used to control high blood sugar) 35 units. Review of Resident #1's August 2022, September 2022, and October 2022 printed medication administration records (MARs) revealed there was an entry for Lantus Solostar 100units inject 30-35 units daily, scheduled for 8:00am. Review of Resident #1's Lantus Solostar pharmacy label revealed there were instructions to inject 30-35 units subcutaneous daily. Observation of Resident #1 on 10/05/22 at 9:25 am revealed: -The Administrator administered obtained a flex pen of Lantus Solostar insulin for Resident #1. -She cleansed his right arm and injected 34 units of Lantus insulin. Observation of Resident #1's medication on hand on 10/05/22 at 12:07pm revealed there was one opened flex-pen of Lantus dispensed on 06/20/22. Telephone interview with a representative at Resident #1's Primary Care Provider's (PCP) office on 10/05/22 at 2:25pm revealed: -Resident #1 had an order under his profile for Lantus Solostar 30-35 units subcutaneous daily. -There was no documentation of staff from the facility calling concerning Resident #1's Lantus Solostar. -There was no documentation under Resident #1's profile concerning guidance for the number of units to administer of Lantus Solostar.	C 315	Adminstrator will ASure that all orders will be clarified by PCP Rt, frequency, dose and Right person	11-28-22

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 315	Continued From page 14 Telephone interview with a pharmacist at the facility contracted pharmacy on 10/05/22 at 1:41pm revealed: -Resident #1 had an order dated 06/20/22 for Lantus Solostar 100 units give 30-35 units subcutaneous daily. -There were no notes for guidance concerning the dosage of Lantus to administer daily. -Lantus Solostar was dispensed on 06/20/22 for a 43-day supply if 35 units were given daily. -A 43-day supply was dispensed on 10/05/22. Interview with Resident #1 on 10/05/22 at revealed he received insulin, but he did not know the dose of insulin. Interview with the Administrator on 10/05/22 at 4:15pm revealed: -When she received an order that was not clear, she called the resident's PCP. -She administered 34 units of Lantus to Resident #1 because she thought it was an order in his record. -She knew his FL-2 indicated 35 units, but she thought she was missing an order sheet from Resident #1's record that indicated 34 units should be given. -She knew Resident #1's MARs indicated administering 30-35 units of Lantus. -She remembered a discussion at Resident #1's PCP office to administer 35 units of Lantus daily. -She did not have documentation concerning the discussion with Resident #1's PCP. -She never notified Resident #1's PCP to clarify the order for Lantus Solostar. -She did not notify the pharmacy concerning the entry for Lantus Solostar placed on Resident #1's MARs.	C 315	11/28/22 Administrator will ASSURE any RESIDENTS that is taking Insulin will have the RT, ~~dog~~ dosage, frequency and A CLEAR documentation ##	

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 315	Continued From page 15 -She was responsible for ensuring unclear orders were clarified.	C 315		
C 330	10A NCAC 13G .1004 (a) Medication Administration 10A NCAC 13G .1004 (a) 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: Based on observations, record reviews, and interviews, the facility failed to ensure medication was administered as ordered by a licensed prescribing practitioner for 1 of 3 sampled residents (#3) related to an order for a sleep aid. The findings are: Review of Resident #3's current FL-2 dated 04/28/22 revealed diagnoses included schizoaffective disorder bipolar type, and hyperlipidemia. Review of Resident #3's subsequent orders revealed there was an order dated 09/26/22 for trazodone 100mg take one-half tablet at bedtime and a separate sentence that trazodone may be repeated one time as needed.	C 330	Administrator will Asure that Med's will be on hand AS ordered from PCP also will make sure Pharcmary is notified	11-28-22

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 330	Continued From page 16 Review of Resident #3's August 2022 printed medication administration record (MAR) revealed: -There was an entry for trazodone 100mg take one-half tablet at bedtime and a separate sentence that indicated may repeat one time as needed, scheduled as an as needed medication. -There was no documentation of administration of trazodone. Review of Resident #3's September 2022 printed medication administration record (MAR) revealed: -There was an entry for trazodone 100mg take one-half tablet at bedtime and a separate sentence that indicated may repeat one time as needed, scheduled as an as needed medication. -There was no documentation of administration of trazodone. Review of Resident #3's October 2022 printed medication administration record (MAR) revealed: -There was an entry for trazodone 100mg take one-half tablet at bedtime and a separate sentence that indicated may repeat one time as needed, scheduled as an as needed medication. -There was no documentation of administration of trazodone. Observation of Resident #3's medications on hand on 10/05/22 at 12:09pm revealed there was no trazodone available to administer. Telephone interview with a representative at Resident #3's Primary Care Provider's (PCP) office on 10/05/22 at	C 330	Administrator will ASURE medication will be on hand by having a reminder using a calander or electronic device to check Med's in house week early so they wont run out 11-28-22	

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 330	Continued From page 17 2:25pm revealed Resident #1's PCP did not prescribe trazodone for him. Telephone interview with a pharmacist at the facility contracted pharmacy on 10/05/22 at 1:41pm revealed: -There were 3 different orders for trazodone for Resident #3. -There was an order dated 08/12/22 for trazodone 50mg at bedtime and may repeat once as needed. -There was a note to discontinue the order dated 08/12/22. -There was an order dated 09/26/22 for trazodone 50mg at bedtime and may repeat once as needed. -The order was placed on the MAR as an as needed medication. -He thought the PCP did not understand the difficulty of placing certain orders on the MAR. -A new order came in electronically on 10/05/22 for trazodone 50mg at bedtime, may repeat once as needed. -A bubble package of 30 whole tablets of trazodone 50mg were dispensed on 10/05/22 and another bubble package of 30 one-half tablets of 100mg trazodone tablets were dispensed on 10/05/22. -The trazodone 50mg tablets were for the bedtime dose and the trazodone 100mg one-half tablets were for the as needed dose. -Before 10/05/22, trazodone was last dispensed for Resident #3 on 03/04/22. Interview with the Administrator/medication aide (MA) on 10/05/22 at 4:15pm revealed: -She thought Resident #3's trazodone was as needed.	C 330	ADMINISTRATOR WILL ASURE THE DOSAGE RT, FREQUENCY WILL BE CORRECT ON MAR and doctors order	11/28/22

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 330	Continued From page 18 -She was responsible for reviewing orders, but she thought Resident #3's trazodone order was an as needed order. -She did not review the order for Resident #3's trazodone, she trusted that his MAR was accurate for trazodone. -She knew she did not have any trazodone available to administer, but she thought it was an as needed medication. -She called the pharmacy on 10/05/22 and the pharmacy would deliver trazodone for Resident #3. -Resident #3's entry on the MAR was wrong for trazodone. -She had not administered trazodone to Resident #3 at bedtime daily. -She was responsible for administering medications as ordered by the PCP. Attempted telephone interview with Resident#3's Psychiatric provider on 10/05/22 at 2:54pm was unsuccessful. Attempted interview with Resident #3 on 10/05/22 at 3:12pm was unsuccessful.	C 330		
C 331	10A NCAC 13G .1004 (b) Medication Administration 10A NCAC 13G .1004 (b) Medication Administration b) The facility shall assure that only staff meeting the requirements in Rule .0403 of this Subchapter shall administer medications, including the preparation of medications for administration.	C 331		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 331	Continued From page 19 This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that only staff meeting the requirements of a medication aide shall administer medications. The findings are: Review of the male staff personnel file revealed: -He was a personal care aide (PCA). -He did not have any of the required training for a medication aide (MA). Observation of the facility on 10/05/22 at 8:00am revealed: -There was a male staff person on duty. -He notified the Administrator at 8:36am via telephone. Observation of the Administrator on 10/05/22 at 9:20am revealed: -She arrived at the facility at 9:20am. -She began administering medications to the residents at 9:25am. Observation of residents' medications on 10/05/22 at 9:24am revealed: -The medications were stored in a locked hall closet. -The medications were packaged in a multidose package and labeled with the time the medications were due. Telephone interview with a resident on 10/05/22 at 2:10pm revealed:	C 331	ADMINSTRATOR WILL ASURE that ONLY CERIFICD MED TECH WILL GIVE OUT MEDS TO RESIDENTS ADMINSTRATOR WILL HAVE A CERIFICD MED TECH ON SCHEDULE AND ALSO HAVE PRN MED TECH IN PLACE IN CASE OF ADMINSTRATOR ISNT AVAIBLE	11/28/22

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 331	Continued From page 20 -The male staff worked at the facility as a caregiver for the residents. -The male staff administered medications to the residents sometimes, but the Administrator already had them prepared in cups. -The male staff administered the medications when the Administrator did not administer the medications. Interview with another resident on 10/05/22 at 2:59pm revealed: -The male staff only gave medications to the residents when the Administrator was busy. -Most of the time, the Administrator gave medication to the residents. -He could not remember the last time the male staff gave medications to him. Interview with a third resident on 10/05/22 at 3:27pm revealed the male staff, the female staff and the Administrator had given his medications to him in the past. Interview with a fourth resident on 10/05/22 at 3:19pm revealed the male staff and the Administrator administered his medications. Interview with the male staff on 10/05/22 at 3:05pm revealed: -He was a family member of the Administrator and he had worked at the facility for years. -He was not a medication aide (MA), but he was a personal care aide (PCA). -He gave medications sometimes and the Administrator	C 331	Administrator will ASURE NO other staff will give out Med's only the Cerified staff.	11/28/22

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 331	Continued From page 21 prepared the medications in cups for each resident. -The Administrator placed the residents' initials on the cups, so he could distinguish which cup to give to each resident. -He last gave medications to the residents a couple of nights ago. -He did not sign the residents' MARs after he administered the medications. -He had not completed training for being a medication aide (MA). Interview with the Administrator on 10/05/22 at 4:15pm revealed: -She only asked the male staff to administer medications when she could not make it to the facility. -She was the only MA and emergencies occurred. -There had been recent events that prevented her from making it to the facility. -When the events happened, the male staff gave the medications. -She planned to hire another MA to help with medication administration. -She was responsible for ensuring medications were administered by staff who had the required training for MAs.	C 331	Administrator will HAVE CERTIFIED MED Tech IN PLACE to GIVE MED'S IF NOT AVAIBLE 11/28/22 Adminstrator will MAKE SURE all documentation is ON MAR and also ON CONTROL SUBSTANCE sheet. By HAVING A REMINDER by USING ELECTRONIC DEVICE ALEXA 11/28/22	
C 367	10A NCAC 13G .1008 (a) Controlled Substances 10A NCAC 13G .1008 (a) Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the	C 367		

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 367	Continued From page 22 resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure there were readily retrievable record for controlled substances by documenting the receipt, administration and disposition for 1 of 1 sampled resident (#2). *The findings are:* Review of Resident #2's current FL-2 dated 12/01/21 revealed: -Diagnoses included bipolar disorder, intellectual disability, attention deficit disorder, seizures, allergic rhinitis, asthma, and chronic obstructive pulmonary disease. -There was an order for clonazepam 1mg without a route and frequency. Review of Resident #2's clonazepam on hand medication label revealed there were instructions to administer clonazepam 1mg take one tablet twice daily. Review of Resident #2's August 2022 printed medication administration record (MAR) revealed: -There was an entry for clonazepam 1 mg take one tablet twice daily, scheduled for 8:00am and 8:00pm. -Clonazepam 1 mg was documented as administered from 08/01/22 to 08/31/22 at 8:00am and 8:00pm. Review of Resident #2's September 2022 printed	C367	Administrator will assure any controlled substance drug will be written on controlled substance sheet also on MAR	11/28/22

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 367	Continued From page 24 Resident #2 on 09/22/22. -A CSCS was sent with each bubble package of controlled substance dispensed. Interview with the Administrator on 10/05/22 at 4:15pm revealed: -She signed the MARS when medications were administered. -She received CSCS from the pharmacy when a resident had a controlled substance ordered. -She never documented administering Resident #2's clonazepam on the CSCSs. -She documented administering the clonazepam on Resident #2's MARs only. -She did not think she needed to document on the CSCS and did not understand the reason for documenting on the CSCS. -She was responsible ensuring there was a record documenting the receipt, administration and disposition of controlled substances. Attempted interview with Resident #2's Primary Care Provider on 10/05/22 at 2:55pm was unsuccessful.	C 367	Administrator will A Secondary control Substance drugs will be documented on control Substance Sheet	11/28/22

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE

DHSR LIMITED USE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER IDENTIFICATION NUMBER: FCL-001-047	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETED: 10/05/22

NAME OF PROVIDER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Tender Love and Care	**532 Greenwood Dr, Burlington, NC 27215**

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)	COMPLETE DATE
C 367	Continued From page 23 medication administration record (MAR) revealed: -There was an entry for clonazepam 1 mg take one tablet twice daily, scheduled for 8:00am and 8:00pm. -Clonazepam 1 mg was documented as administered from 09/01/22 to 09/30/22 at 8:00am and 8:00pm. Review of Resident #2's October 2022 printed medication administration record (MAR) revealed: -There was an entry for clonazepam 1 mg take one tablet twice daily, scheduled for 8:00am and 8:00pm. -Clonazepam 1 mg was documented as administered from 10/01/22 to 10/04/22 at 8:00am and 8:00pm. Review of Resident #2's controlled substance count sheet (CSCS) revealed: -There was a CSCS attached by a staple to each bubble package of clonazepam dispensed on 09/22/22. -The attached CSCS were blank. -There were no previous CSCS for August 2022 or September 2022. Observation of Resident #2's medication on hand on 10/05/22 at 12:42pm revealed: -There were two bubble packages of clonazepam dispensed on 09/22/22. -One bubble package contained 15 of 30 clonazepam tablets. -The other bubble package contained 30 of 30 clonazepam tablets. Telephone interview with a pharmacist at the facility's contracted pharmacy on 10/05/22 at 1:41pm revealed: -There were 60 tablets of clonazepam dispensed for	C 367	11/28/22 Administrator will make sure any control substance drug will be given as ordered by PCP or physic doctor also documented	

PROVIDER LICENSEE OR LICENSEE DESIGNEE'S SIGNATURE TITLE DATE