STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001177	A. BUILDING: _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE AND BEYOND FAMILY CARE	1616 E WEBB AVENUE BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on March 16, 2023.	C 000		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure staff immediately documented the administration of medications for 2 of 3 sampled residents (Residents #1 and #2). The findings are: 1. Review of Resident #1's current FL-2 dated 09/27/22 revealed: -Diagnoses included wedge compression fracture, history of falls, muscle weakness, dementia, and hypertension. -There was an order for amlodipine (used to treat high blood pressure) 5mg every morning. -There was an order for citalopram (used for anxiety and depression) 20mg every morning. -There was an order for vitamin D (used as a	C 341		

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C 341	Continued From page 1	C 341		

supplement) 1000 units every morning.
-There was an order for melatonin (used for sleep) 3mg every night.

Review of Resident #1's signed physician's order dated 02/13/23 revealed there was an order for acetaminophen (used for pain) 500mg twice daily.

Review of Resident #1's March 2023 medication administration record (MAR) revealed:
-The Medication Aide (MA) failed to document the administration of amlodipine 5mg, citalopram 200mg, vitamin D 1000 units, and acetaminophen 500mg on 03/16/23 at 8:00am.
-The MA failed to document the administration of acetaminophen 500mg and melatonin 3mg on 03/15/23 at 8:00pm.

Refer to the interview with the MA on 03/16/23 at 10:50am.

Refer to the interview with the Supervisor-in-Charge (SIC) on 03/16/23 at 10:55am.

Refer to the telephone interview with the Administrator on 03/16/23 at 1:50pm.

2. Review of Resident #2's current FL-2 dated 03/02/23 revealed:
-Diagnoses included orthostatic hypotension, syncope and collapse, muscle weakness, diabetes mellitus 2, and hyperlipidemia.
-There was an order for Thera care patches (used for pain) apply one patch topically every morning and remove every night.
-There was an order for diclofenac gel (used for joint pain) 2 grams four times daily.
-There was an order for metformin (used to manage blood sugar) 500mg twice daily.

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C 341	Continued From page 2 Review of Resident #2's March 2023 medication record administration (MAR) revealed: -The Medication Aide (MA) failed to document the administration of Thera care patch, diclofenac gel, and metformin 500mg on 03/16/23 at 8:00am. -The MA failed to document the administration of metformin 500mg and the removal of Thera care patch on 03/15/23 at 8:00pm. Refer to the interview with the MA on 03/16/23 at 10:50am. Refer to the interview with the Supervisor-in-charge (SIC) on 03/16/23 at 10:55am. Refer to the telephone interview with the Administrator on 03/16/23 at 1:50pm. _____ Interview with the Medication Aide (MA) on 03/16/23 at 10:50am revealed: -She administered the 8:00am medications the morning of 03/16/23. -She thought she signed the MAR after she had administered each resident's medications. Interview with the Supervisor-in-Charge (SIC) on 03/16/23 at 10:55am revealed: -She administered 8:00pm medications on 03/15/23. -She forgot to sign the resident's MAR because she was in a rush. -She should have documented the administration of the medications immediately after the medications were administered. Telephone interview with the Administrator on	C 341		

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C 341	Continued From page 3 03/16/23 at 1:50pm revealed: -The MAs should document on the MAR immediately after administration of medications. -She expected the MAs to follow the 6 rights of medication administration each time the MAs administered medications.	C 341		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the accuracy of the medication administration records (MARs) for 1 of 3 sampled residents (#2) related to a medication used for pain associated with gas	C 342		

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C 342	Continued From page 4 (#2). The findings are: Review of Resident #2's current FL-2 dated 03/02/23 revealed: -Diagnoses included orthostatic hypotension, syncope and collapse, muscle weakness, diabetes mellitus, and hyperlipidemia. -There was an order for simethicone (used to treat gas pain) 80mg every 6 hours. Review of Resident #2's March 2023 medication administration record (MAR) from 03/03/23 to 03/16/03 revealed: -There was no entry for simethicone 80mg four times daily to be administered. -There was no documentation that simethicone was administered from 03/03/23 to 03/16/23. -There was an entry for simethicone 80mg every 6 hours as needed. Observation of Resident #2's medication on hand on 03/16/23 at 10:55am revealed: -There was a weekly multi-dose pack (MDP) that contained simethicone 80mg available for administration. -The multi-dose pack had four individual MDP for each day. -Simethicone 80mg was in each MDP for each day to be administered four times daily. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 03/16/23 at 11:10am revealed: -The pharmacy had an order for simethicone 80mg four times daily for Resident #2 dated 03/03/23. -The pharmacy dispensed 28 tablets of simethicone tablets weekly in the MDP.	C 342		

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C 342	Continued From page 5 -The facility staff was responsible for hand-writing the medication on the March 2023 MAR. -The pharmacy used the admission FL-2 for medication orders. Interview with the Medication Aide (MA) at 10:50am revealed: -She worked on 03/03/23 when Resident #2 was admitted. -She wrote the medications on the March 2023 MAR. -She used the medication list faxed to the facility from the previous facility for Resident #2's medication orders. -She did not know she should use the FL-2 for the admission medication orders. Interview with the Supervisor-in-Charge at 10:55am revealed: -The MA wrote the admission medications on March 2023 MAR for Resident #2 from the list of medications faxed to the facility from the previous facility. -The MA should have written the medications listed on the Resident #2's FL-2. -She realized the simethicone was entered on the MAR as an "as needed" order when it was a scheduled dose every 6 hours. -She discontinued the simethicone as needed and forgot to handwrite the scheduled dose of simethicone 80mg on the MAR. Telephone interview with the Administrator on 03/16/23 at 1:50pm revealed: -She knew Resident #2 had an order for simethicone 80mg every 6 hours. -There was confusion if the simethicone should be scheduled every 6 hours or as needed. -The FL-2 had simethicone 80mg every 6 hours; that is the order that was used.	C 342		

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C 342	Continued From page 6 -She did not know simethicone 80 mg was not on the March 2023 MAR. -She did not know the MAs where administering a medication and not documenting the medication. -She expected the MAs to compare medications administered to the MAR prior to administering the medications.	C 342		