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	FCL001177	A. BUILDING: _____ B. WING _____	06/27/2024

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 and the Alamance County Department of Social Services conducted an annual and follow-up survey on June 27, 2024.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Health Service Regulation, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Health Service Regulation if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the	C 007		

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C 007	Continued From page 1 Division of Health Service Regulation for review of any possible changes that may be required to the building. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that the resident's evacuation capabilities were different from the evacuation capabilities listed on the facility's license for 2 of 4 sampled residents who did not exit the facility during a fire drill. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 5 ambulatory residents. Observation of the facility on 06/27/24 at 8:00am revealed four residents resided in the facility. Review of the facility's fire rehearsal schedule dated 01/10/24 at 3:30pm revealed: -The residents were in the living room. -The fire alarm sounded, and everyone made it safely outside. -The amount of time to evacuate was 5 minutes. Review of the facility's fire rehearsal schedule dated 02/13/24 at 10:00am revealed: -The residents were in their rooms.	C 007		

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C 007	Continued From page 2	C 007		

-The fire alarm sounded, and everyone made it safely outside.
-The amount of time to evacuate was 5 minutes.

Review of the facility's fire rehearsal schedule dated 03/01/24 at 7:30am revealed:
-The residents were in the dining room eating breakfast.
-The fire alarm sounded, and everyone made it safely outside.
-The amount of time to evacuate was 6 minutes.

Review of the facility's fire rehearsal schedule dated 04/01/24 at 7:15am revealed:
-The residents were in the living room.
-The fire alarm sounded, and everyone made it safely outside.
-The amount of time to evacuate was 6 minutes.

Review of the facility's fire rehearsal schedule dated 05/10/24 at 1:30pm revealed:
-The fire alarm sounded, alerted the residents, who exited the facility to the driveway.
-The amount of time to evacuate was 6 minutes.

Observation of the facility on 06/27/24 at 12:59pm revealed:
-The Supervisor-in-Charge (SIC) activated the smoke detector in the kitchen.
-A loud audible beeping sounded for 2 minutes and 2 seconds.
-Two residents did not exit the facility.

Telephone interview with an Owner on 06/27/24 at 3:29pm and 6:19pm revealed:
-The facility staff and residents practiced fire drills "quite often."
-She knew the staff were not supposed to tell the residents it was a fire drill so a buddy system was implemented so the residents could make sure

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C 007	Continued From page 3 their roommate was with them when exiting. -The facility was licensed for 5 ambulatory residents. -She had not notified construction because she did not know she needed to. -She knew if a resident's condition changed, she was supposed to call construction, but she did not know a resident not leaving the facility during a fire drill was considered non-ambulatory. -She thought ambulatory was "walking." Attempted telephone interview with the Administrator on 06/27/24 at 1:10pm was unsuccessful. Refer to Tag C0022 10A NCAC 13G .0302(b) Design and Construction.	C 007		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's	C 022		

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C 022	Continued From page 4 current license for 2 of 4 sampled residents (#3, #4) who did not respond to a fire drill. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 5 ambulatory residents. Review of the facility's fire alarm procedure revealed there was no fire alarm procedure available to be reviewed. Review of the facility's fire rehearsal schedule dated 01/10/24 at 3:30pm revealed: -The residents were in the living room. -The fire alarm sounded, and everyone made it safely outside. -The amount of time to evacuate was 5 minutes. Review of the facility's fire rehearsal schedule dated 02/13/24 at 10:00am revealed: -The residents were in their rooms. -The fire alarm sounded, and everyone made it safely outside. -The amount of time to evacuate was 5 minutes. Review of the facility's fire rehearsal schedule dated 03/01/24 at 7:30am revealed: -The residents were in the dining room eating breakfast. -The fire alarm sounded, and everyone made it safely outside. -The amount of time to evacuate was 6 minutes. Review of the facility's fire rehearsal schedule dated 04/01/24 at 7:15am revealed: -The residents were in the living room. -The fire alarm sounded, and everyone made it safely outside.	C 022		

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C 022	Continued From page 5 -The amount of time to evacuate was 6 minutes. Review of the facility's fire rehearsal schedule dated 05/10/24 at 1:30pm revealed: -The fire alarm sounded, alerted the residents, and exited the facility to the driveway. -The amount of time to evacuate was 6 minutes. 1. Review of Resident #3's current FL-2 dated 02/20/24 revealed: -Diagnoses included dementia, diabetes, and hypertension. -The resident was ambulatory. -The resident was intermittently disoriented. Review of Resident #3's Resident Register revealed an admission date of 02/29/24. Review of Resident #3's assessment and care plan dated 05/20/24 revealed: -The resident was sometimes disoriented. -The resident was forgetful and needed reminders. Observation of the facility on 06/27/24 at various times between 8:15am-6:45pm revealed: -Resident #3 was ambulatory. -Resident #3 aimlessly walked around the facility and would be redirected by staff. Interview with the Supervisor-in-Charge (SIC) on 06/27/24 at 11:27am revealed: -She could not make sense of what Resident #3 talked about. -Resident #3 could not remember what she ate after just eating. -Resident #3 needed guidance to go to the bathroom and her room. -Resident #3 needed more "coaching" than the other residents.	C 022		

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C 022	Continued From page 6 Observation of the facility on 06/27/24 at 12:59pm revealed: -The SIC activated the smoke detector in the kitchen. -A loud audible beeping sounded for 2 minutes and 2 seconds. -Resident #3 was seated on the couch in the living room. -Resident #3 remained seated and did not exit the facility. Interview with the SIC on 06/27/24 at 1:03pm revealed she did not think Resident #3 would know what a smoke detector alarm was or know to go outside. Telephone interview with Resident #3's family member on 06/27/24 at 3:15pm revealed: -There were some things Resident #3 remembered and some things she did not remember. -Resident #3's memory was "on and off." -Resident #3 had moments when she was "good" and other times things may not register. -If Resident #3 heard a smoke detector she would find someone to see what was happening because the resident did not like loud noises. -Resident #3 would not know to go outside if she was by herself, but if someone else went outside she would go too. Telephone interview with an Owner on 06/27/24 at 3:29pm revealed: -Resident #3 thought she was at work a lot of the time. -Resident #3 was usually directed out of the facility during fire drills by another resident. Based on observations, record reviews, and	C 022		

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interviews it was determined Resident #3 was not interviewable.

Attempted telephone interview with the Administrator on 06/27/24 at 1:10pm was unsuccessful.

Attempted telephone interview with Resident #3's primary care provider (PCP) on 06/27/24 at 3:09pm was unsuccessful.

Refer to the interview with the SIC on 06/27/24 at 1:03pm.

Refer to the telephone interview with an Owner on 06/27/24 at 3:29pm.

2. Review of Resident #4's current FL-2 dated 12/20/23 revealed:
-Diagnoses included vascular dementia with delusional hallucinations, a history of right middle cerebral artery stroke, chronic obstructive pulmonary disease, and hypertension.
-The resident was semi-ambulatory.
-The resident was intermittently disoriented.

Review of Resident #4's Resident Register revealed an admission date of 11/28/23.

Review of Resident #4's assessment and care plan revealed there was no assessment and care plan available to be reviewed.

Observation of the facility on 06/27/24 at various times between 8:15am-6:45pm revealed Resident #4 was able to independently get up and down from chairs and move about the facility with her walker.

Interview with the Supervisor-in-Charge (SIC) on

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C 022	Continued From page 8 06/27/24 at 11:27am revealed: -Resident #4 had dementia. -Resident #4 talked about things that did not make sense. -Resident #4 would talk about things that were not current almost every day. -Resident #4 thought she was sixty four years old and she was almost 84. -Resident #4 thought everyone was talking about her. -Resident #4 might know what a smoke detector alarm was but would not know to go outside. Observation of the facility on 06/27/24 at 12:59pm revealed: -The SIC activated the smoke detector in the kitchen. -A loud audible beeping sounded for two minutes and 2 seconds. -Resident #4 was seated on the couch in the living room. -After one minute Resident #4 walked down the hallway toward the bathroom. -Another resident told Resident #4 there was a fire drill, and she was supposed to go outside, the resident looked at the resident, then continued to go into the bathroom and shut the door. Interview with the other resident on 06/27/24 at 1:00pm revealed: -She thought the residents could tell each other what to do during a fire drill. -"We were told by staff the residents could tell each other what to do during fire drills." Interview with the SIC on 06/27/24 at 1:03pm revealed Resident #4 might know what a smoke detector alarm was but would not know to go outside.	C 022		

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C 022	Continued From page 9 Interview with Resident #4 on 06/27/24 at 4:51pm revealed: -She did not know what the smoke alarm was. -She did not hear a smoke alarm today, 06/27/24. -If she heard a smoke alarm, she would "check out the smoke detector." Telephone interview with Resident #4's family member on 06/27/24 at 4:53pm revealed: -Resident #4's memory was good and bad. -A lot of Resident #4's memory was good, she remembered family members. -Resident #4's main problem was what she imagined. -Resident #4 was diagnosed with vascular dementia after a stroke about four years ago. -She thought if someone told Resident #4 what a smoke detector alarm was and what to do, the resident would know what to do. -If the facility had not practiced fire drills, that may be why Resident #4 did not know what to do during the fire drill. Telephone interview with an Owner on 06/27/24 at 3:29pm revealed: -Resident #4 had been acting "strange", normally the resident was more aware. -Resident #4 was diagnosed with cancer and since the diagnosis, the resident had mentally declined. -Sometimes Resident #4 was "with it and sometimes she was not." Attempted telephone interview with the Administrator on 06/27/24 at 1:10pm was unsuccessful. Attempted telephone interview with Resident #4's primary care provider (PCP) on 06/27/24 at 4:48pm was unsuccessful.	C 022		

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C 022	Continued From page 10 Refer to the interview with the SIC on 06/27/24 at 1:03pm. Refer to the telephone interview with an Owner on 06/27/24 at 3:29pm. _____ Interview with the SIC on 06/27/24 at 1:03pm revealed: -The facility staff conducted fire drills once a month. -She rounded up the residents and directed them outside. -She went from room to room to tell the residents it was a fire drill. -She did not think the residents would go out on their own or not without her telling them. -She did not know she was not supposed to tell the residents it was a fire drill, but it made sense not to. Telephone interview with an Owner on 06/27/24 at 3:29pm revealed: -The facility staff and residents practiced fire drills "quite often." -She knew the staff were not supposed to tell the residents it was a fire drill so a buddy system was implemented so the residents could make sure their roommate was with them when exiting. _____ The facility failed to ensure the evacuation capabilities of 2 of 4 residents were consistent with the current license of 5 ambulatory residents as evidenced by two residents residing in the facility who did not respond to a fire drill; one resident was diagnosed with dementia and was forgetful, needed reminders, and was sometimes disoriented (#3) and another resident was diagnosed with vascular dementia and was intermittently disoriented (#4). This failure was	C 022		

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C 022	Continued From page 11 detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/27/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 11, 2024.	C 022		
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 observation, interviews, and record reviews, the facility failed to ensure that 1 of 3 sampled staff (B) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: Review of Staff B's, personal care aide (PCA), personnel record revealed: -Staff B was hired on 02/09/24. -There was no documentation that a HCPR check was completed prior to hire. Interview with Staff B on 06/27/24 at 5:02pm revealed:	C 145		

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C 145	Continued From page 12 -She started to work at the facility in May 2024. -She did not know what a HCPR was or if an HCPR check was completed prior to hire. Observations of Staff B on 06/27/24 from 8:15am-6:45pm revealed Staff B cooked and served meals to the residents and cleaned the residents' rooms. Telephone interview with an Owner on 06/27/24 at 6:19pm revealed: -She thought a HCPR had been completed on Staff B upon hire. -The Office Manager was responsible for completing the new hire packet which contained the HCPR. -"Maybe it got lost." Review of Staff B's HCPR check completed on 06/27/24 revealed Staff B was not listed on the HCPR. Attempted interview with the Office Manager on 06/27/24 at 6:19pm was unsuccessful.	C 145		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a	C 231		

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resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource.

This Rule is not met as evidenced by:
Based on observations, records reviews, and interviews, the facility failed to ensure an assessment was completed for 4 of 4 sampled residents (#1, #2, #3, #4) within 30 days of admission and annually.

The findings are:

1. Review of Resident #1's current FL-2 dated 03/04/24 revealed diagnoses included type II diabetes, hypertension, and hyperlipidemia.

Review of Resident #1's Resident Register revealed an admission date of 04/11/23.

Review of Resident #1's Care Plan dated 04/19/23 revealed:
-The assessment/care plan was signed by the primary care provider (PCP).
-Resident #1 required supervision with eating and ambulation, limited assistance with bathing, and extensive assistance with toileting, dressing, and grooming.

Review of Resident #1's care plan revealed there

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 231	Continued From page 14 was no care plan completed for 2024. Interview with Resident #1 on 06/27/24 at 1:16pm revealed she did not need assistance from staff; she was independent. Attempted interview with the Office Manager on 06/27/24 at 6:19pm was unsuccessful. Attempted telephone interview with the Administrator on 06/27/24 at 1:10pm was unsuccessful. Refer to the interview with the Supervisor-in-Charge (SIC) on 06/27/24 at 5:11pm. Refer to the telephone interview with an Owner on 06/27/24 at 6:16pm. 2. Review of Resident #2's current FL-2 dated 11/29/23 revealed diagnoses included toxic metabolic encephalopathy, schizoaffective disorder, s/p ankle fusion, and borderline personality disorder. Review of Resident #2's Resident Register revealed an admission date of 11/28/23. Review of Resident #2's care plan revealed: -The care plan had not been completed but was dated with an 11/23/23 assessment date. -The assessment did not include information on Resident #2's personal care needs; the section was blank. -The care plan was not signed by the Supervisor in Charge (SIC). Interview with Resident #2 on 06/27/24 at 8:20am revealed:	C 231		

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ABOVE AND BEYOND FAMILY CARE	1616 E WEBB AVENUE BURLINGTON, NC 27217

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C 231	Continued From page 15 -She was independent with dressing, bathing, and showering. -She transferred from her wheelchair to her bed and the shower without assistance by standing and pivoting. Attempted interview with the Office Manager on 06/27/24 at 6:19pm was unsuccessful. Attempted telephone interview with the Administrator on 06/27/24 at 1:10pm was unsuccessful. Refer to the interview with the Supervisor-in-Charge (SIC) on 06/27/24 at 5:11pm. Refer to the telephone interview with an Owner on 06/27/24 at 6:16pm. 3. Review of Resident #3's current FL-2 dated 02/20/24 revealed diagnoses included dementia, diabetes, and hypertension. Review of Resident #3's Resident Register revealed an admission date of 02/29/24. Review of Resident #3's Care Plan dated 05/20/24 revealed: -The assessment/care plan was signed by the primary care provider (PCP). -The assessment did not include information on Resident #3's personal care needs; the section was blank. Based on observations, record reviews, and interviews it was determined Resident #3 was not interviewable. Attempted interview with the Office Manager on	C 231		

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C 231	Continued From page 16 06/27/24 at 6:19pm was unsuccessful. Attempted telephone interview with the Administrator on 06/27/24 at 1:10pm was unsuccessful. Refer to the interview with the Supervisor-in-Charge (SIC) on 06/27/24 at 5:11pm. Refer to the telephone interview with an Owner on 06/27/24 at 6:16pm. 4. Review of Resident #4's current FL-2 dated 12/20/23 revealed diagnoses included vascular dementia with delusional hallucinations, a history of right middle cerebral artery stroke, chronic obstructive pulmonary disease, and hypertension. Review of Resident #4's Resident Register revealed an admission date of 11/28/23. Review of Resident #4's care plan revealed there was no care plan available to be reviewed. Based on observations, record reviews, and interviews it was determined Resident #4 was not interviewable. Attempted interview with the Office Manager on 06/27/24 at 6:19pm was unsuccessful. Attempted telephone interview with the Administrator on 06/27/24 at 1:10pm was unsuccessful. Refer to the interview with the Supervisor-in-Charge (SIC) on 06/27/24 at 5:11pm.	C 231		

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C 231	Continued From page 17 Refer to the telephone interview with an Owner on 06/27/24 at 6:16pm. _____ Interview with the Supervisor-in-Charge (SIC) on 06/27/24 at 5:11pm revealed: -Care plans were the responsibility of the SIC or the Office Manager. -She had not completed care plans for residents; the PCP filled the care plans out and signed them. Telephone interview with an Owner on 06/27/24 at 6:16pm revealed: -Care plans were completed by the residents' PCP. -The facility had "just switched" PCPs for the residents and care plans were being updated. -The facility staff did not complete care plans; the PCP was responsible for completing them. -If the care plan was not complete the Office Manager/SIC should fax the care plan back to the PCP.	C 231		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's	C 315		

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C 315	Continued From page 18 record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure clarification of medication orders for 1 of 3 sampled residents (#1) related to an order for an iron supplement. The findings are: Review of Resident #1's current FL-2 dated 03/04/24 revealed: -Diagnoses included type II diabetes, hypertension, and hyperlipidemia. -There was no order for ferrous sulfate (iron supplement) 325mg. Review of Resident #1's hospital discharge FL-2 dated 01/31/24 revealed: -Resident #1 had a diagnosis of iron deficiency anemia. -There was an order for Ferrous Sulfate 325mg three times daily with meals. Review of Resident #1's hospital discharge summary dated 03/08/24 revealed a current medication list which included Ferrous Sulfate 325mg once daily. Review of Resident #1's April 2024 medication administration record (MAR) revealed: -There was an entry for Ferrous Sulfate 325mg three times daily with an administration time of 8:00am, 12:00pm and 5:00pm. -There was documentation that Ferrous Sulfate 325mg was administered three times daily from 04/01/24-04/30/24. Review of Resident #1's May 2024 MAR revealed:	C 315		

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C 315	Continued From page 19 -There was an entry for Ferrous Sulfate 325mg three times daily with an administration time of 8:00am, 12:00pm and 5:00pm. -There was documentation that Ferrous Sulfate 325mg was administered three times daily from 05/01/24-05/31/24. Review of Resident #1's June 2024 medication administration record (MAR) from 06/03/24-06/27/24 revealed: -There was an entry for Ferrous Sulfate 325mg three times daily with an administration time of 8:00am, 12:00pm and 5:00pm. -There was documentation that Ferrous Sulfate 325mg was administered three times daily from 06/03/24-06/27/24. Observation of Resident #1's medications on hand on 06/27/24 at 9:07am revealed: -Resident #1's medication was in a multi-dose package and each card contained one week of medication, labeled daily. -Ferrous Sulfate 325mg was included in three separate bubbles with the directions to administer daily at 8:00am, 12:00pm and 5:00pm. Interview with the Supervisor-in-Charge (SIC) on 06/27/24 at 9:30am revealed she administered all of the tablets in Resident #2's multidose package when she administered the resident's medications; she did not dispose of any of the medications. Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/27/24 at 2:08pm revealed: -The original order for Resident #1's Ferrous Sulfate was dated 01/31/24 and was for Ferrous Sulfate 325mg three times daily with meals and it was cycle filled monthly.	C 315		

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C 315	Continued From page 20	C 315		

-They had not received Resident #1's FL-2 dated 03/04/24 or hospital discharge summary.
-If Resident #1's FL-2 dated 03/04/24 was received at the pharmacy, the pharmacy team would have checked to see if the medication was to be continued since it was not listed on the FL-2.
-He expected the facility to send all new FL-2s to the pharmacy.
-New prescriptions were received for Resident #1's medications on 06/03/24, which included Ferrous Sulfate 325mg three times daily.

Telephone interview with a medical assistant for Resident #1's primary care provider (PCP) on 06/27/24 at 2:40pm revealed Resident #1's current order for Ferrous Sulfate 325mg was three times daily.

Second interview with the SIC on 06/27/24 at 4:00pm revealed:
-She did not catch that Resident #1's Ferrous Sulfate 325mg three times daily was not listed on the FL-2 dated 03/04/24.
-When Resident #1 returned from a hospitalization on 03/08/24, the hospital did not send a new FL-2 for Resident #1.
-She had reached out to the hospital requesting a new FL-2 but did not receive one.
-She used the medication list on Resident #1's hospital discharge summary dated 03/08/24 to know the resident's current medications.
-When the resident returned, the medication list should have been compared to the resident's current MAR and if it did not match, the SIC who was working should have gotten clarification.

Telephone interview with an Owner on 06/27/24 at 6:19pm revealed:
-A resident could not return to the facility from a

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C 315	Continued From page 21 hospitalization without a new FL-2. -If a resident returned to the facility without a new FL-2 and the medication list did not match, the Office Manager or any SIC should contact the pharmacy or the provider to get clarification on the medication order. Attempted interview with the Office Manager on 06/27/24 at 6:19pm was unsuccessful. Attempted telephone interview with the Administrator on 06/27/24 at 1:10pm was unsuccessful.	C 315		
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: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#1) related to a medication used to treat urinary incontinence and a medication used to treat muscle spasms. The findings are: Review of Resident #1's current FL-2 dated	C 330		

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C 330	Continued From page 22 03/04/24 revealed diagnoses included type II diabetes, hypertension, and hyperlipidemia. a. Review of Resident #1's current FL-2 dated 03/04/24 revealed there was an order for Oxybutynin (used to treat symptoms of an overactive bladder) 15mg once daily. Review of Resident #1's hospital discharge summary dated 03/08/24 revealed a diagnosis of chronic kidney disease, stage IV. Review of Resident #1's physician's orders dated 06/03/24 revealed an order for Oxybutynin 5mg once daily. Review of Resident #1's June 2024 medication administration record (MAR) from 06/03/24-06/27/24 revealed: -There was an entry for Oxybutynin 15mg with an administration time of 8:00am. -There was documentation that Oxybutynin 15mg was administered daily from 06/03/24-06/27/24. Observation of Resident #1's medications on hand on 06/27/24 at 9:07am revealed: -Resident #1's medication was in a multi-dose package and each card contained one week of medication, labeled daily. -Oxybutynin 15mg was included in the multidose package with the directions to administer daily. Interview with the Supervisor-in-Charge (SIC) on 06/27/24 at 9:30am revealed she administered all the tablets in Resident #2's multidose package when she administered the resident's medications; she did not dispose of any of the tablets. Telephone interview with a pharmacist at the	C 330		

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C 330	Continued From page 23	C 330		

facility's contracted pharmacy on 06/27/24 at 2:08pm revealed:
-The current order for Resident #1's Oxybutynin was dated 01/31/24 and was for Oxybutynin 15mg once daily and it was cycle filled monthly.
-They had not received Resident #1's order for Oxybutynin 5mg dated 06/03/24.
-He would have expected staff at the facility to have followed up with the pharmacy to see why the medication had not been delivered.

Telephone interview with a medical assistant for Resident #1's primary care provider (PCP) on 06/27/24 at 2:40pm revealed:
-Resident #1's current order for Oxybutynin was for 5mg once daily.
-Resident #1's Oxybutynin was changed from 15mg to 5mg because the medication caused kidney damage and the resident already had kidney disease.
-The PCP was not concerned because the dosage had not been changed as of 06/27/24 but did want the dosage changed from 15mg to 5mg as ordered on 06/03/24.

Interview with the SIC on 06/27/24 at 4:00pm revealed:
-She did not know Resident #1's Oxybutynin had been changed from 15mg to 5mg.
-The Office Manager was responsible for processing new orders including making the change on the MAR.
-If she had known there was a new order, as the SIC she could have processed the order too.
-If she had seen a change documented on the MAR, she would have known to look for the new medication to be delivered.

Attempted interview with the Office Manager on 06/27/24 at 6:19pm was unsuccessful.

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C 330	Continued From page 24 Attempted telephone interview with the Administrator on 06/27/24 at 1:10pm was unsuccessful. Refer to the telephone interview with an Owner on 06/27/24 at 6:19pm. b. Review of Resident #1's after-visit summary dated 05/01/24 revealed an order for Cyclobenzaprine (used as a muscle relaxant to treat pain and stiffness caused by muscle spasms) 10mg at bedtime. Review of Resident #1's physician's order dated 06/03/24 revealed an order for Cyclobenzaprine 10mg every night at bedtime as needed. Revie of a clarification form from the facility's contracted pharmacy dated 06/04/24 revealed: -The pharmacy was clarifying the previous order for Cyclobenzaprine 10mg every night was being discontinued and the new order was for the Cyclobenzaprine 10mg as needed. -The order was signed by Resident #1's primary care provider (PCP) on 06/05/24 confirming the order was to be changed to as needed. Review of Resident #1's June 2024 medication administration record (MAR) from 06/03/24-06/27/24 revealed: -There was an entry for Cyclobenzaprine 10mg with an administration time of 8:00pm. -There was documentation that Cyclobenzaprine 10mg was administered daily from 06/03/24-06/27/24. Observation of Resident #1's medications on hand on 06/27/24 at 9:07am revealed: -Resident #1's medication was in a multi-dose	C 330		

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C 330	Continued From page 25	C 330		

package and each card contained one week of medication, labeled daily.
- Cyclobenzaprine 10mg was included in the multidose package with the directions to administer daily.

Second observation of Resident #1's medication on 06/27/24 at 4:26pm revealed a punch card dated 06/04/24 for Resident #1's Cyclobenzaprine 10mg to be administered at bedtime as needed; there were 16 of 16 tablets on the punch card.

Interview with the Supervisor-in-Charge (SIC) on 06/27/24 at 9:30am revealed she administered all the tablets in Resident #2's multidose package when she administered the resident's medications; she did not dispose of any of the tablets.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/27/24 at 2:08pm revealed:
-The current order for Resident #1's Cyclobenzaprine 10mg was dated 06/03/24 and was for as needed.
-Resident #1's previous order for Cyclobenzaprine 10mg had been scheduled.
-The facility staff would be responsible for writing on the MAR the order change.
-The facility staff should have removed the Cyclobenzaprine 10mg from the multidose package and disposed of the medication if it was not needed on that date for the resident.
-A single package of Cyclobenzaprine 10mg was dispensed on 06/04/24 for 16 tablets to be used as needed.

Interview with the SIC on 06/27/24 at 4:00pm revealed:

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C 330	Continued From page 26 -Resident #1 was administered Cyclobenzaprine 10mg nightly at 8:00pm. -Resident #1 did not have any problems with sleeping. -She thought she saw the order change from daily to as needed. -She administered medication by reviewing the MAR and the medications on hand. -She should have caught the medication change. Attempted second telephone interview with Resident #1's PCP on 06/27/24 at 3:09pm was unsuccessful. Attempted interview with the Office Manager on 06/27/24 at 6:19pm was unsuccessful. Attempted telephone interview with the Administrator on 06/27/24 at 1:10pm was unsuccessful. Refer to the telephone interview with an Owner on 06/27/24 at 6:19pm. _____ Telephone interview with an Owner on 06/27/24 at 6:19pm revealed: -New orders for medications were usually sent directly to the pharmacy by the provider. -Medication changes should be made on the MAR by the Office Manager and the Office Manager would notify the SIC of the change. -The SIC would then know they needed to follow up on the change.	C 330		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration	C 342		

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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, interviews, and record reviews, the facility failed to ensure the electronic medication administration records were accurate for 1 of 3 sampled residents including an order for finger stick blood sugar (FSBS) and a weekly injection (#1).

The findings are:

Review of Resident #1's current FL-2 dated 03/04/24 revealed diagnoses included type II diabetes, hypertension, and hyperlipidemia.

1. Review of Resident #1's current FL-2 dated 03/04/24 revealed an order for finger stick blood sugar (FSBS) once weekly

Review of Resident #1's April 2024 medication

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 _____	06/27/2024

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
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administration record (MAR) revealed:
-There was an entry for FSBS once daily with a scheduled administration time of 8:00am.
-There was documentation that FSBS were checked daily from 04/01/24-04/30/24.

Review of Resident #1's May 2024 MAR revealed:
-There was an entry for FSBS once daily with a scheduled administration time of 8:00am.
-There was documentation that FSBS were checked daily from 05/01/24-05/31/24.

Review of Resident #1's June 2024 MAR from 06/03/24-06/27/24 revealed:
-There was an entry for FSBS once daily with a scheduled administration time of 8:00am.
-There was documentation that FSBS were checked daily from 06/03/24-06/27/24.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 06/27/24 at 2:08pm revealed:
-They had not received Resident #1's FL-2 dated 03/04/24.
-The current order for FSBS was to check the resident's FSBS daily dated 02/28/24.

Interview with Resident #1 on 06/27/24 at 1:16pm revealed staff checked her FSBS "about" once a week.

Interview with the Supervisor-in-Charge (SIC) on 06/27/24 at 4:00pm revealed:
-She checked Resident #1's FSBS once weekly.
-She documented the results of Resident #1's weekly FSBS on a blood sugar log.
-She had not noticed she was documenting daily FSBS when the order was for once weekly.
-"I guess I was not looking at what I was

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C 342	Continued From page 29 documenting." Review of Resident #1's FSBS log revealed the resident's FSBS was documented weekly. Telephone interview with an Owner on 06/27/24 at 6:19pm revealed: -She expected the SIC to document on the MAR when the FSBS were being done. -If the order was to check Resident #1's FSBS once weekly, the documentation should reflect once weekly. Attempted interview with the Office Manager on 06/27/24 at 6:19pm was unsuccessful. Attempted telephone interview with the Administrator on 06/27/24 at 1:10pm was unsuccessful. Refer to the telephone interview with an Owner on 06/27/24 at 6:19pm. 2. Review of Resident #1's after-visit summary dated 05/01/24 revealed an order for Invega Sustenna 117mg/0.75ml once monthly intramuscular injection. Review of Resident #1's June 2024 MAR revealed: -There was an entry for Invega Sustenna 117mg/0.75ml once-monthly intramuscular injection with a scheduled administration time of 8:00am. -There was documentation that the Invega injection was completed daily from 06/01/24-06/30/24. Interview with Resident #1 on 06/27/24 at 1:16pm revealed she went to her mental health provider	C 342		

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C 342	Continued From page 30 once a month for a shot, usually at the end of the month. Interview with the Supervisor-in-Charge (SIC) on 06/27/24 at 4:00pm revealed: -Resident #1's Invega injection was given by the mental health provider monthly at the mental health provider's office. -She had not noticed she was documenting the injection daily. -She usually wrote across the MAR that the injection was done by the mental health provider. -"I guess I was not looking at what I was documenting." Telephone interview with an Owner on 06/27/24 at 6:19pm revealed she was not aware the SIC was documenting Resident #1's monthly Invega injection daily. Attempted interview with the Office Manager on 06/27/24 at 6:19pm was unsuccessful. Attempted telephone interview with the Administrator on 06/27/24 at 1:10pm was unsuccessful. Refer to the telephone interview with an Owner on 06/27/24 at 6:19pm. _____ Telephone interview with an Owner on 06/27/24 at 6:19pm revealed: -She expected the SIC to document accurately on the MAR. -The Office Manager should compare the MARs monthly when the MARs for the next month were delivered and make appropriate changes to the MAR. -She had not audited the MARs to ensure the staff documented correctly.	C 342		

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