

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER ABOVE AND BEYOND FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1616 E WEBB AVENUE BURLINGTON, NC 27217		
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C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 08/05/25 with an exit conference via telephone on 08/06/25.	C 000		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure that 1 of 3 sampled staff (Staff B) who administered medications had completed the state-approved 5-hour, 10-hour, or 15-hour medication aide (MA) training courses and the Medication Administration Competency Validation Clinical Skills Checklist as required. The findings are: Review of Staff B's personnel record revealed: -There was no documentation Staff B passed the MA written exam. -There was no documentation Staff B completed the Medication Administration Competency Validation Clinical Skills Checklist. -There was no MA employment verification form for Staff B. -There was no documentation Staff B completed	C 131		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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C 131	Continued From page 1 the state-approved 5, 10-hour, or 15-hour MA training courses. Review of residents' medication administration records (MAR) for June 2025, July 2025 and August 2025 revealed Staff B had administered medications to the residents on multiple occasions. Telephone interview with Staff B on 08/06/25 at 10:02am revealed: -She had completed the 15-hour MA training course years ago. -She received a MA training course certificate at the end of the training. -She was checked off by a nurse from the pharmacy. -She had been employed with the facility since 2014. -The personnel records were being changed from a loose folder to a folder with clasp. -The papers must have been lost in the transfer from one folder to another. Telephone interview with the Administrator on 08/06/25 at 3:39pm revealed: -Staff B had a 15-hour certificate for completing the MA training course. -The class was taught by the Registered Nurse (RN) from the pharmacy. -The RN validated the medical skills for Staff B. -Staff B had been employed for 10 years or more. -Staff B was responsible for auditing the staff records once a month. -Staff B should have notified her if there was anything missing from the personnel folders. Prior to the exit of the survey on 08/06/25, a copy of Staff B's certificate for successfully passing the MA training course and passing state exam or the	C 131		

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C 131	Continued From page 2 clinical skills checklist were not provided.	C 131		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled staff (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 personnel record revealed: -Staff B was hired as a medication aide (MA) -There was no hire date listed. -There was no documentation a HCPR check was completed prior to hire. Telephone interview with Staff B on 08/06/25 at 10:02am revealed: -She thought the Administrator had checked her HCPR prior to working at the facility. -She had been employed with the facility since 2014. -All the requirements needed were completed when she was hired as a MA. -The personnel records were being changed from a loose folder to a folder with clasp. -The papers must have been lost in the transfer	C 145		

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C 145	Continued From page 3 from one folder to another. Telephone interview with the Administrator on 08/06/25 at 3:39pm revealed: -She would have check Staff B's HCPR when she was hired, which was more than 10 years ago. -She did not know why the HCPR report was missing from Staff B's personnel record. -Staff B had been employed for 10 years or more. -Staff B was responsible for auditing the staff records once a month. -Staff B should have notified her if there was anything missing from the personnel folders. Prior to the exit of the survey on 08/06/25, a copy of Staff B's HCPR was not provided.	C 145		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) had a criminal background check completed upon hire. The findings are: Review of Staff B's personnel record revealed: -There was no hire date documented in the personnel record. -There was no signed consent for a criminal	C 147		

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C 147	Continued From page 4 background check in her personnel record. -There was no documentation of a criminal background check in Staff B's personal record. Telephone interview with Staff B on 08/06/25 at 10:02am revealed: -She had signed a release to have a criminal background check completed when she was hired. -She had been employed with the facility since 2014. -All the requirements needed were completed when she was medication aide (MA). -The personnel records were being changed from a loose folder to a folder with clasp. -The papers must have been lost in the transfer from one folder to another. Telephone interview with the Administrator on 08/06/25 at 3:39pm revealed: -She checked Staff B's criminal background when Staff B was hired. -She did not know why the criminal background report was missing from Staff B's personnel record. -Staff B had been employed for 10 years or more. -Staff B was responsible for auditing the staff records once a month. -Staff B should have notified her if there was anything missing from the personnel folders. Prior to the exit of the survey on 08/06/25, a copy of Staff B's criminal background check was not provided.	C 147			
C 148	10A NCAC 13G .0406 (a)(8) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications	C 148			

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C 148	Continued From page 5 (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 1 of 3 sampled staff (Staff B) prior to hire. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a medication aide (MA). -There was no job description. -There was no documentation a drug screen had been completed. Telephone interview with Staff B on 08/06/25 at 10:02am revealed: -She had been employed with the facility since 2014. -She did a drug screen before she started working at the facility. -All the requirements needed were completed when she was hired as a MA. -The personnel records were being changed from a loose folder to a folder with clasp. -The papers must have been lost in the transfer from one folder to another. Telephone interview with the Administrator on 08/06/25 at 3:39pm revealed: -She had a drug screen completed on Staff B	C 148		

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C 148	Continued From page 6 when she was hired. -She did not know why the drug screening report was missing from Staff B's personnel record. -Staff B had been employed for 10 years or more. -Staff B was responsible for auditing the staff records once a month. -Staff B should have notified her if there was anything missing from the personnel folders. Prior to the exit of the survey on 08/06/25, a copy of Staff B's drug screen was not provided.	C 148		
C 270	10A NCAC 13G .0904 (c)(7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure matching therapeutic menus for food service staff for guidance when preparing meals for 2 of 2 sampled residents (#1 and #4) with a physician's order for a diabetic diet (#1) and a heart healthy diet (#4). The findings are: Observation of the kitchen on 08/05/25 revealed there was no therapeutic diet menus for staff	C 270		

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C 270	Continued From page 7 guidance when preparing meals. 1. Review of Resident #1's current FL-2 dated 01/08/25 revealed: -Diagnosis included diabetes mellitus type 2. -There was an order for a diabetic diet. Observation of the lunch meal on 08/05/25 from 12:05 to 12:30pm revealed: -Resident #1 was served a ham sandwich on white bread with mayonnaise, one - half cup of macaroni and cheese, one - half cup of mixed vegetables, and a fruit cup of peaches and pears. -Resident #1 ate 100 percent of her lunch meal. Observation of the dinner meal on 08/05/25 from 5:00pm to 5:25pm revealed: Resident #1 was served a slice of pepperoni pizza, a tossed salad with dressing, and two cookies. -Resident #1 ate 100% of her dinner meal. Interview with Resident #1 on 08/05/25 at 3:25pm revealed: -She was a diabetic. -She was not on a special diet; she ate what she wanted to eat. -She did not know she had an order for a diabetic diet. -She liked sweets, and she would eat them sometimes. Interview with the Business Office Manager (BOM) on 08/05/25 at 12:25pm revealed: -She did not know Resident #1 had an order for a diabetic diet. -She prepared Resident #1 the same meal as the other residents. Interview with the medication aide (MA) on	C 270		

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C 270	Continued From page 8 08/05/25 at 10:05am revealed: -Resident #1's meals were prepared just like the other residents. -Resident #1 received a regular diet. -She did not know Resident #1 had an order for a diabetic diet. -No one told her Resident #1 had an order for a diabetic diet. Attempted telephone interview with Resident #4's Primary Care Provider (PCP) on 08/05/25 at 4:10pm and 08/06/25 at 9:15am was unsuccessful. Refer to the interview with the BOM on 08/05/25 at 12:25pm. Refer to the interview with the MA on 08/05/25 at 10:05am. Refer to the interview with the Administrator on 08/06/25 at 3:39pm. 2. Review of Resident #4's current FL-2 dated 07/30/25 revealed: -Diagnoses included heart failure, hypertension and left ventricular hypertrophy due to hypertensive disease. -There was an order for a heart healthy diet. Observation of the lunch meal on 08/05/25 from 12:05 to 12:30pm revealed: -Resident #4 was served a ham sandwich on white bread with mayonnaise, one - half cup of macaroni and cheese, one - half cup of mixed vegetables, and a fruit cup of peaches and pears. -Resident #4 ate 100 percent of her lunch meal. Observation of the dinner meal on 08/05/25 from 5:00pm to 5:25pm revealed:	C 270		

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C 270	Continued From page 9 Resident #4 was served a slice of pepperoni pizza, a tossed salad with dressing, and two cookies. -Resident #4 ate 100% of her dinner meal. Interview with Resident #4 on 08/05/25 at 5:25pm revealed: -She did not know if she was ordered a special diet. -She knew she should watch her salt intake. -She ate the food that was served to her; she received the same food as the other resident. Interview with the Business Office Manager (BOM) on 08/05/25 at 12:25pm revealed: -She knew Resident #4 had an order for a heart healthy diet. -So she did not allow Resident #4 to add salt to her food. -She was served the same food the other residents were served. Interview with the mediation aide (MA) on 08/05/25 at 10:05am revealed: -Resident #4's meals were prepared just like the other residents. -Resident #4 received a regular diet. -She did not know Resident #4 had an order for a heart healthy diet. -No one told her Resident #4 had an order for a heart healthy diet. -She thought she had seen the therapeutic diet book before but she was not sure. Attempted telephone interview with Resident #4's (PCP) Primary Care Provider on 08/05/25 at 4:10pm and 08/06/25 at 9:15am was unsuccessful. Refer to the interview with the BOM on 08/05/25	C 270		

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C 270	Continued From page 10 at 12:25pm. Refer to the interview with the MA on 08/05/25 at 10:05am. Refer to the interview with the Administrator on 08/06/25 at 3:39pm. Interview with the BOM on 08/05/25 at 12:25pm revealed: -She prepared the lunch meal each day she worked. -She served each resident the same meal. -She did not know what a therapeutic diet menu was. -She had never been told what a therapeutic diet menu was. Interview with the MA on 08/05/25 at 10:05am revealed: -She had seen therapeutic diet menus in a notebook in the business office. -She did not know where the therapeutic diet menu was now. Interview with the Administrator on 08/06/25 at 3:39pm revealed: -She did not know the residents were not being served therapeutic diets as ordered. -There were therapeutic menus in a notebook in the business office. -The MAs knew to pull the therapeutic menu from the notebook and place the therapeutic menu in the kitchen when a resident was ordered a therapeutic diet. -She expected the MAs to know where the therapeutic menus were and to use them with each meal.	C 270			

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C 315	Continued From page 11	C 315		
C 315	10A NCAC 13G .1002(a) Medication Orders 10A NCAC 13G .1002 Medication Orders (a) A family care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 2 of 3 sampled residents (#1 and #2) related to a medication for constipation (#1) and ear drops (#2). The findings are: 1. Review of Resident #1's current FL-2 dated 01/08/25 revealed: -Diagnoses included cerebral anoxic injury, schizoaffective disorder, diabetes mellitus type and osteoarthritis. -There was an order for milk of magnesium 30mls (used for constipation) every 4 hours as needed. Review of Resident #1's signed physician's order dated 04/29/25 revealed there was an order for milk of magnesium 30mls every night.	C 315		

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C 315	Continued From page 12 Review of Resident #1's August 2025 medication administration record (MAR) from 08/01/25 to 08/05/25 revealed: -There was no entry for milk of magnesium 30mls every night. -There was no documentation milk of magnesium was administered every night as ordered. Observation of Resident #1's medications on hand on 08/05/25 at 10:03am revealed: -There was a bottle of milk of magnesium dispensed on 07/21/25 that was $\frac{3}{4}$ full. -The directions on the prescription label was take 5ml every four hours as needed for constipation. Telephone interview with a representative from the facility's contracted pharmacy on 08/05/25 at 2:06pm revealed: -Resident #1 had an order for milk of magnesium 30mls every 4 hours as needed for constipation. -The pharmacy did not have a scheduled order for milk of magnesium for Resident #1. Interview with the medication aide (MA) on 08/05/25 at 10:05am revealed: -Resident #1 had an order for milk of magnesium daily. -Resident #1 became constipated easily and needed something every day for her bowels. -She was constipated last week and took a suppository and drank prune juice along with the milk of magnesium. Interview with another MA on 08/06/25 at 10:02am revealed: -Resident #1 had an order for milk of magnesium every day. -She did not realize the milk of magnesium was not on the MAR	C 315		

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C 315	Continued From page 13 -It was the responsibility of the MA who checked the MARS to ensure all medications were on the MARs as ordered. -She did not review the new MARs for the August 2025. Telephone interview with the Administrator on 08/05/25 at 4:00pm revealed: -The MA should clarify the order with the physician if the MA was not sure how to administer a medication. -She expected the MA to clarify any medication order they were unsure of. Attempted telephone interviews with the PCP on 08/05/25 at 4:10pm and 08/06/25 at 9:15am were unsuccessful. 2. Review of Resident #2's current FL-2 dated 12/03/24 revealed: -Diagnoses included schizoaffective disorder, toxic metabolic encephalopathy, and borderline personality disorder. Review of Resident #2's signed physicians' orders dated 07/01/25 revealed there was an order for neomycin and polymyxin B sulfates and hydrocortisone otic solution 1 % (used to treat bacterial infections) four drops in left ear twice daily dated 07/01/25. Review of Resident #2's July 2025 medication administration record (MAR) revealed: -There was an entry for neomycin and polymyxin B sulfates and hydrocortisone otic solution 1 % instill two drops in the left ear twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation neomycin and polymyxin B sulfates and hydrocortisone otic	C 315		

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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 315	Continued From page 14 solution was administered twice daily. Review of Resident #2's August 2025 MAR from 08/01/25 to 08/05/25 revealed: -There was an entry for neomycin and polymyxin B sulfates and hydrocortisone otic solution 1 % instill four drops in the left ear twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation neomycin and polymyxin B sulfates and hydrocortisone otic solution was administered twice daily from 08/01/25 to 08/04/25 and 08/05/25 at 8:00am. Observation of Resident #1's medications on hand on 08/05/25 at 10:03am revealed: -There was a bottle of neomycin and polymyxin B sulfates and hydrocortisone otic solution 1 % available for administration dispensed on 05/29/25 to administer 3 drops into the left ear twice daily. -There was a second bottle of neomycin and polymyxin B sulfates and hydrocortisone otic solutions available for administration dispensed on 07/01/25 to administer 4 drops into the left ear twice daily. Telephone interview with a representative from the facility's contracted pharmacy on 08/05/25 at 9:08am revealed: -Resident #2 had an order for neomycin and polymyxin B sulfates and hydrocortisone otic solution 1 % dated 07/01/25 to administer four drops in the left ear twice a day. -The pharmacy did not have a discontinued or a hold order for Resident #2's ear drops. -The facility was responsible for changing the order from twice daily to four time daily on the MAR.	C 315		

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C 315	Continued From page 15 Interview with Resident #2 on 08/05/25 at 3:45pm revealed: -She had surgery on her left ear about 2 months ago. -She was receiving chemotherapy and radiation to her left ear. -Her oncologist told her to stop taking the ear drops in her left ear while she was taking chemotherapy and radiation. Interview with the MA on 08/05/25 at 10:05am revealed: -She had not administered ear drops to Resident #2 in a couple of weeks. -Resident #2's ear drops were placed on hold while she was taking chemotherapy. -She documented wrong on the MAR. Telephone interview with a representative from Resident #2's Oncologist office on 08/06/25 at 12:56pm revealed: -Resident #2 was seen in the office on 07/01/25 and she was ordered neomycin and polymyxin B sulfates and hydrocortisone otic solution 1 % four drops twice daily to her left ear. -There was no order to discontinue the ear drops or to place the ear drops on hold. Telephone interview with the Administrator on 08/05/25 at 4:00pm revealed: -The MA should clarify a medication order with the physician if the MA was not sure of the frequency of the medication. -The MA should clarify a medication order if they were not sure if the order was as needed or scheduled. -She expected the MA to clarify any medication order they were unsure of.	C 315			

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C 330	Continued From page 16	C 330		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 3 sampled residents (#1 and #3) including two insulins and a medication for depression (#1) and a pain medication (#3). The findings are: 1. Review of Resident #1's current FL-2 dated 01/08/25 revealed diagnoses included diabetes mellitus type 2 and schizoaffective disorder. a. Review of Resident #1's current FL-2 dated 01/08/25 revealed: -There was an order to check blood sugar (BS) readings three times daily before meals. -There was an order for Humalog 100 units/ml (a rapid-acting insulin used to lower blood sugar levels) inject per sliding scale (SS), if the BS reading was 160 - 200, give 1 unit; 201 - 240, give 2 units; 241 - 280, give 3 units; if 281 to 300, give 4 units; if greater than 300, give 5 units and	C 330		

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C 330	Continued From page 17 notify the Primary Care Provider (PCP). Review of Resident #1's PCP's after visit summary dated 05/23/25 revealed: -Resident #1's BS check in the PCP's office was 200. -Resident #1 had an order for Humalog 100 units/ml inject per SS if the BS reading was 160 - 200, give 1 unit; 201 - 240, give 2 units; 241 - 280, give 3 units; if 281 to 300, give 4 units; if greater than 300, give 5 units and notify the PCP. -Resident #1's A1C (the hemoglobin A1C measures the average level of blood sugar over the previous 3 months. The normal A1C level is below 5.7%) in January 2025 was 9.3% and in May 2025 was 9.4%. -Resident #1's A1C goal was less than 8%. -Resident #1 was to continue sliding scale insulin (SSI) as ordered. Review of Resident #1's June 2025 medication administration record (MAR) revealed: -There was an entry to check BS readings three times daily before meals scheduled at 8:00am, 12:00pm and 5:00pm. -There was documentation BS readings were checked three times daily before meals. -There was an entry for Humalog 100 units/ml inject per SS, if the BS reading was 160 - 200, give 1 unit; 201 - 240, give 2 units; 241 - 280, give 3 units; if 281 to 300, give 4 units; if greater than 300, give 5 units and notify the PCP. -There was a BS reading of 221 documented on 06/03/25; there was no documentation of how many units of Humalog was administered on 06/03/25. -There were no other BS readings documented on the MAR. Review of Resident #1's June 2025 BS reading	C 330		

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C 330	Continued From page 18 log from 06/01/25 to 06/30/25 revealed: -The BS log had an 8:00am, 12:00pm, and 5:00pm column for the BS readings to be documented. -There were BS readings documented three times daily from 06/1/25 to 06/30/25, ranging from 101 to 221. Review of Resident #1's July 2025 MAR revealed: -There was an entry to check BS readings three times daily before meals scheduled at 8:00am, 12:00pm and 5:00pm. -There was documentation BS readings were checked three times daily before meals; the BS readings were not recorded on the MAR. -There was an entry for Humalog 100 units/ml inject per SS, if the BS reading was 160 - 200, give 1 unit; 201 - 240, give 2 units; 241 - 280, give 3 units; if 281 to 300, give 4 units; if greater than 300, give 5 units and notify the PCP. -There was no documentation that Humalog SSI was administered from 07/01/25 to 07/31/25. Review of Resident #1's July 2025 BS reading log from 07/01/25 to 07/31/25 revealed: -The BS log had an 8:00am, 12:00pm, and 5:00pm column for the BS readings to be documented. -There were BS readings documented three times a day from 07/1/25 to 07/24/25, ranging from 101 to 157. -There was no documentation of BS readings from 07/25/25 to 07/31/25. Review of Resident #1's August 2025 MAR from 08/01/25 to 08/05/25 revealed: -There was an entry to check BS readings three times daily before meals scheduled at 8:00am, 12:00pm and 5:00pm. -There was documentation BS readings were	C 330		

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C 330	Continued From page 19 checked three times a day before meals; the BS readings were not recorded on the MAR. -There was an entry for Humalog 100 units/ml inject per SSI, if the BS reading was 160 - 200, give 1 unit; 201 - 240, give 2 units; 241 - 280, give 3 units; if 281 to 300, give 4 units; if greater than 300, give 5 units and notify the PCP. -There was no documentation that Humalog SSI was administered from 08/01/25 to 08/05/25. Review of Resident #1's August 2025 BS reading log from 08/01/25 to 08/05/25 revealed: -The BS log had an 8:00am, 12:00pm, and 5:00pm column for the BS readings to be documented. -There were BS readings documented three times a day from 08/1/25 to 08/04/25, ranging from 107 to 135. -There was a BS reading documented on 08/05/25 at 8:00am of 205. Review of the manufacturer's manual for Brand A glucometers revealed: -The glucometer tracked the average blood sugar (BS) readings over different time periods. -The glucometer allowed for the viewing of the average of the BS readings within a 7-day, 14-day, and 30-day period. -The average BS readings were displayed when the glucometer was turned on. -If there were no average values over the past 7-days, 14-days, or 30 days, three dashes would be displayed for the 7-day, 14-day, and 30-day averages. Review of Resident #1's Brand A glucometer on 08/05/25 at 10:45am revealed: -There was no current date or time on the glucometer when it was turned on. -There were no 7-day, 14-day, or 30-day	C 330		

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C 330	Continued From page 20 averages for review; three dashes were displayed. -On 06/01/25 at 7:46am, there was a BS reading of 180. -On 06/03/25 at 7:20am, there was a BS reading of 212. -On 06/05/25 at 6:56am, there was a BS reading of 208. -On 06/07/25 at 7:55am, there was a BS reading of 207. -There were no other BS readings for June 2025 on the glucometer. -There were no BS readings for July 2025 on the glucometer. -There were no BS readings for August 2025 on the glucometer. -There was no BS reading of 205 as documented on the BS log for the morning of 08/05/25. Based on review of the glucometer readings compared to the BS log it was determined that the readings in the glucometer were not the same as the readings documented on the BS log for four days in June 2025 and there were no BS readings for the remainder of June 2025, July 2025 or August 2025 in the glucometer. Observation of Resident #1's medications on hand on 08/05/25 at 9:56am revealed there was a Humalog injection pen with 210 units of insulin available for administration dispensed on 02/13/25. Observation of the medication aide (MA) checking Resident #1's BS at 11:37am before the lunch meal revealed: -Resident #1's BS reading was 543. -At 11:45am, the MA administered 5 units of Humalog insulin and notified the PCP. -At 1:02pm, the MA received an order to recheck	C 330			

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C 330	Continued From page 21 Resident #1's BS. -Resident #1's BS reading was 570. -The MA received an order to administer Humalog insulin 12 units and recheck Resident #1's BS in one hour. -At 2:16pm, Resident #1's BS was 419. -The MA received an order to administer Humalog 8 units and recheck Resident #1's BS in one hour. -At 3:45pm, Resident #1's BS reading was 352; the MA notified the PCP for further instructions. Second review of Resident #1's Brand A glucometer on 08/05/25 at 3:45pm revealed: -There was no current date or time on the glucometer when it was turned on. -There were 7-day, 14-day, and 30-day averages for review; the average was 471 for 7-day, 14-day, and 30-day. -At 11:37am, there was a BS reading of 543. -At 1:02pm, there was a BS reading of 570. -At 2:16pm, there was a BS reading of 419. -At 3:45pm, there was a BS reading of 352. Telephone interview with a representative from the facility's contracted pharmacy on 08/05/25 revealed: -The pharmacy had an order for Humalog SS as follows: if the BS reading was 160 - 200, give 1 unit; 201 - 240, give 2 units; 241 - 280, give 3 units; if 281 to 300, give 4 units; if greater than 300, give 5 units and notify the PCP. -The pharmacy dispensed one pen of Humalog 100 units/ml on 02/13/25. Interview with Resident #1 on 08/05/25 at 11:10am to 3:45pm revealed: -She received an insulin injection every morning; she did not know the name of the insulin. -She did not receive insulin injections at lunch or	C 330		

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C 330	Continued From page 22 dinner. -She had received three injections since lunch today, 08/05/25. -Today was the first day she remembered getting injections after lunch and into the afternoon. -She went with her peer support to the library and to the food bank today, 08/05/25. -She had a cupcake and a candy bar while she was out. -She felt fine today; she had no complaints. Interview with the MA on 08/05/25 at 10:05am revealed: -She checked Resident #1's BS before meals from 07/24/25 to 07/31/25. -The July 2025 BS log was not in the MAR notebook, so she wrote the BS readings on a piece of scrap paper. -She forgot to transfer the BS readings to the July 2025 BS log. -She did not know where the scrap of paper was with the BS readings; it was probably thrown away. Interview with the same MA on 08/05/25 at various times between 10:45am and 2:52pm revealed: -The SSI "threw me off" when Resident #1 was admitted to the facility. -She did not know if she should give the scheduled morning insulin and the Humalog SSI at the same time; it was confusing to her. -After a few days, she called the pharmacy to get clarification on when she should administer the Humalog insulin. -She checked Resident #1's BS three times a day before meals. -Resident #1's BS this morning, 08/05/25, was 165 not 205 as documented on the BS log. -She documented the wrong BS reading on the	C 330		

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C 330	Continued From page 23 BS log this morning, 08/05/25. -She did not give Resident #1 the Humalog SSI this morning because Resident #1's BS had been good, and she did not think Resident #1 needed the Humalog SSI. -Resident #1's BS reading of 167 must be in another glucometer. Observation of the MA on 08/05/25 at 11:05am revealed she was in the medication room/office looking for a second glucometer. Interview with the same MA on 08/05/25 at various times between 10:45am and 2:52pm revealed: -She could not locate the second glucometer; the night MA must have done something with it. -She ordered two new glucometers when Resident #1 was admitted to the facility. -She did not know why, but both glucometers had been used on Resident #1. -The BS readings for June, July, and August 2025 must be in the glucometer that she could not locate. -There were no other residents in the facility who received BS checks. -She had administered Humalog insulin to Resident #1 when she was first admitted to the facility, but she had not needed the SSI recently. Telephone interview with the Administrator on 08/05/25 at 4:00pm revealed: -Resident #1 had an order to check her BS three times daily before meals and to administer SSI as needed based on the BS reading. -She expected Resident #1's BS to be checked as ordered and the insulin administered as ordered. -It was important to know what Resident #1's BS was so she could be administered the correct	C 330		

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C 330	Continued From page 24 dosage of insulin. Attempted telephone interviews with the PCP on 08/05/25 at 4:10pm and 08/06/25 at 9:15am were unsuccessful. Refer to the telephone interview with the Administrator on 08/05/25 at 4:00pm. b. Review of Resident #1's after visit summary dated 05/23/25 revealed: -Resident #1's BS check was 200 in the office. -Resident #1 had an order for Lantus 20 units (a long-acting insulin used to improve and maintain blood sugar levels) every morning. -Resident #1's Lantus was increased to 24 units every morning. Review of Resident #1's signed physician order dated 05/23/25 revealed an order for Lantus 24 units every morning. Review of Resident #1's June 2025 MAR revealed: -There was an entry for Lantus 100 units/ml inject 24 units subcutaneously (SQ) every morning with a scheduled administration time of 8:00am. -There was documentation Lantus was injected every morning from 06/01/25 to 06/30/25. Review of Resident #1's July 2025 MAR revealed: -There was an entry for Lantus 100 units/ml inject 24 units SQ every morning with a scheduled administration time of 8:00am. -There was documentation Lantus was injected every morning from 07/01/25 to 07/31/25. Review of Resident #1's August 2025 MAR from 08/01/25 to 08/05/25 revealed: -There was an entry for Lantus 100 units/ml inject	C 330		

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C 330	Continued From page 25 24 units SQ every morning with a scheduled administration time of 8:00am. -There was documentation Lantus was injected every morning from 08/01/25 to 08/05/25. Observation of Resident #1's medications on hand on 08/05/25 at 9:56am revealed there was a Lantus injection pen with 260 units of insulin available for administration, dispensed on 06/15/25. Telephone interview with a representative from the facility's contracted pharmacy on 08/05/25 at 2:06pm revealed: -The pharmacy had an order for Lantus 24 units subcutaneously every morning dated 05/23/25 for Resident #1. -The pharmacy dispensed three 3ml pens of Lantus 100units/ml on 05/23/25 and on 06/15/25. -Three Lantus pens would last 36 days if Resident #1 received 24 units of Lantus every morning. -The three Lantus pens dispensed on 06/15/25 would have lasted until 08/03/25. -The facility had to notify the pharmacy when insulin pens were needed; they were not on automatic refill. Interview with Resident #1 on 08/5/25 at 11:10am revealed she received an injection every morning but did not know the name of the insulin or how much she was administered. Interview with the MA on 08/05/25 at 2:42pm revealed: -She gave Resident #1 Lantus insulin every morning. -She did not know how long the Lantus insulin pen would last. -She did not know why there were 260 units of	C 330			

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NAME OF PROVIDER OR SUPPLIER ABOVE AND BEYOND FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1616 E WEBB AVENUE BURLINGTON, NC 27217		
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C 330	Continued From page 26 Lantus remaining in the insulin pen. -She did not have to order the Lantus insulin from the pharmacy each month; the pharmacy would send the Lantus insulin each month with the multi-dose pack. Interview with the Administrator on 08/05/25 at 4:00pm revealed: -Resident #1 had an order to administer Lantus 24 units each morning. -She was not sure how long the Lantus insulin pen would last if Resident #1 received 24 units each morning. -She did not know there were 260 units of Lantus insulin remaining in the insulin pen that should have been empty on 08/03/25. -If Resident #1's BS got too high, Resident #1 could go into shock, and it could be fatal for Resident #1. -She expected the MAs to check Resident #1's BS and administer insulin as ordered. Attempted telephone interview with the PCP on 08/05/25 at 4:10pm and 08/06/25 at 9:15am were unsuccessful. Refer to the telephone interview with the Administrator on 08/05/25 at 4:00pm. c. Review of Resident #1's signed physician's order dated 07/15/25 revealed there was an order to increase sertraline 100mg (used to treat depression) daily. Review of Resident #1's July 2025 MAR from 07/18/25 to 07/31/25 revealed: -There was a hand-written entry dated 07/15/25 for sertraline 100mg take one tablet daily with a scheduled administration time of 8:00am. -There was documentation sertraline 100mg was	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER ABOVE AND BEYOND FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 330	Continued From page 27 administered every morning from 07/18/25/ to 07/31/25. Observation of Resident #1's medications on hand on 08/05/25 at 9:56am revealed: -There was a punch card with 7 of 15 sertraline tablets remaining with a dispensed date of 07/15/25. -There was a multi-dose pack for the week of 07/30/25 to 08/05/25 in the medication room. -The sertraline 100mg tablet was dispensed in the multi-dose pack the week of 07/30/25 to 08/05/25. Telephone interview with a representative from the facility's contracted pharmacy on 08/06/25 at 3:14pm revealed: -The pharmacy had an order to increase sertraline from 75mg to 100mg daily dated 07/15/25. -The pharmacy dispensed a punch card with 14 sertraline 100mg tablets on 07/15/25. -The punch card contained enough sertraline 100mg tablets for Resident #1 to be administered one tablet a day until the sertraline was placed in the multi-dose pack. -The sertraline 100mg tablets were placed in the multi-dose pack and dispensed on 07/28/25 with a start date of 07/30/25. -There should be no sertraline 100mg remaining in the punch card if the medication was administered as ordered. Interview with the MA on 08/05/25 at 2:42pm revealed: -She administered Resident #1's sertraline every morning with her other medications. -Resident #1's medications came in a multi-dose pack. -She did not realize that the multi-dose pack did	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER ABOVE AND BEYOND FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 330	Continued From page 28 not contain the sertraline 100mg tablet until the week of 07/30/25; she thought it was placed in the multi-dose pack earlier. Telephone interview with the Administrator on 08/05/25 at 4:00pm revealed Resident #1 could become more depressed if she was not being administered her medications as ordered. Attempted telephone interviews with the PCP on 08/05/25 at 4:10pm and 08/06/25 at 9:15am were unsuccessful. Refer to the telephone interview with the Administrator on 08/05/25 at 4:00pm. 2. Review of Resident #3's current FL-2 dated 09/19/24 revealed diagnosis included chronic pain syndrome and migraine headaches. Review of Resident #3's signed physician order dated 06/28/25 revealed there was an order for morphine 15mg (used to treat severe pain) one tablet twice daily. Review of Resident #3's June 2025 medication administration record (MAR) from 06/28/25 to 06/30/25 revealed: -There was an entry for morphine 15mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation morphine was administered twice daily from 06/28/25 to 06/30/25. Review of Resident #3's July 2025 MAR revealed: -There was an entry for morphine 15mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation morphine was	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER ABOVE AND BEYOND FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1616 E WEBB AVENUE BURLINGTON, NC 27217		
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C 330	Continued From page 29 administered twice daily from 07/01/25 to 07/31/25. Review of Resident #3's August 2025 MAR from 08/01/25 to 08/04/25 revealed: -There was an entry for morphine 15mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation morphine was administered twice daily from 08/01/25 to 08/04/25. Observation of Resident #3's medications on hand on 08/05/25 at 3:30pm revealed there were no morphine 15mg tablets available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 08/05/25 at 2:06pm revealed: -The pharmacy had an order for morphine 15mg twice daily dated 06/28/25. -The pharmacy dispensed 60 morphine 15mg tablets on 06/28/25, which would last until 07/28/25. -Morphine was a scheduled II controlled substance and required a new prescription every month. -The facility was responsible for notifying the pharmacy when the morphine needed to be refilled and the pharmacy would reach out to the physician for a new prescription. -There was no documentation the pharmacy had been notified by the facility that Resident #3 needed a new prescription for morphine. -The pharmacy did not know Resident #3 had been without morphine for a week. Interview with Resident #3 on 08/05/25 at 3:30pm revealed:	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER ABOVE AND BEYOND FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1616 E WEBB AVENUE BURLINGTON, NC 27217		
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C 330	Continued From page 30 -She took pain medication for migraines and body pain. -She hurt "all the time". -She tolerated the pain; there was nothing else to do. Interview with a medication aide (MA) on 08/05/25 at 2:45pm revealed: -She gave Resident #3 her last morphine a few days ago. -The pharmacy had not sent anymore morphine for Resident #3. -She had not called the pharmacy or the Primary Care Provider (PCP) regarding Resident #3 being out of morphine; the pharmacy was responsible for calling the PCP. Telephone interview with another MA on 08/06/25 at 10:02am revealed: -She administered Resident #3 the last morphine 15mg tablet last week. -The MA who worked 7:00am to 7:00pm was responsible for calling the pharmacy to re-order the morphine. -The pharmacy would notify the PCP for a new prescription for the morphine to be refilled. -She did not know if anyone had contacted the pharmacy to inform them that Resident #3 needed more morphine. Telephone interview with the Administrator on 08/05/25 at 4:00pm revealed: -She did not know Resident #3's morphine was not available for administration. -Resident #3 could have excruciating pain if she did not receive the morphine as ordered. -The MA should notify the pharmacy when Resident #3 needed the morphine. -The pharmacy would notify the PCP for a new prescription for morphine.	C 330		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2025
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C 330	Continued From page 31 -If there was a problem obtaining the medication for Resident #3, the MA should have notified her. Attempted telephone interview with the PCP on 08/05/25 at 4:10pm and 08/06/25 at 9:15am were unsuccessful. Refer to the telephone interview with the Administrator on 08/05/25 at 4:00pm. Telephone interview with the Administrator on 08/05/25 at 4:00pm revealed: -The PCP ordered residents' medication for the well-being of the residents. -She expected the MA to administer all medication as ordered. The facility failed to administer medications as ordered to a resident (#1) who had a diagnosis of diabetes and had an order for a long acting insulin in the morning and a short acting insulin based on blood sugar readings three times daily at meals. It was determined that the long acting insulin was not administered as ordered based on dispensed dates and medication on hand. The short-acting insulin could not be administered as ordered because the resident's BS readings were not checked as ordered. A second resident who had diagnoses of chronic pain syndrome and migraine headaches was not administered her pain medication as ordered (#3). This failure put the residents at substantial risk for harm and pain, which constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/06/25. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 09/05/25.	C 330		

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C 342	Continued From page 32	C 342		
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 medication administration records (MAR) were accurate for 1 of 3 sampled residents (#3) including a shampoo. The findings are: Review of Resident #3's current FL-2 dated 09/19/24 revealed diagnoses included seborrheic dermatitis.	C 342		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2025
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C 342	Continued From page 33 Review of Resident #3's current FL-2 dated 09/19/24 revealed there was an order for ketoconazole 2% shampoo (used to treat a dry, itchy scalp) apply 10ml topically to a wet scalp, lather and leave on 3 to 5 minutes and then rinse on Tuesdays. Review of Resident #3's June 2025 MAR revealed: -There was an entry for ketoconazole 2% shampoo apply 10ml topically to a wet scalp, lather and leave on 3 to 5 minutes and then rinse on Tuesdays scheduled at 8:00am. -There was documentation ketoconazole 2% shampoo was applied to wet scalp every Tuesday. Review of Resident #3's July 2025 MAR revealed: -There was an entry for ketoconazole 2% shampoo apply 10ml topically to a wet scalp, lather and leave on 3 to 5 minutes and then rinse on Tuesdays scheduled at 8:00am. -There was documentation ketoconazole 2% shampoo was applied to wet scalp every Tuesday. Review of Resident #3's August 2025 MAR from 08/01/25 to 08/05/25 revealed: -There was an entry for ketoconazole 2% shampoo apply 10ml topically to a wet scalp, lather and leave on 3 to 5 minutes and then rinse on Tuesdays scheduled at 8:00am. -There was documentation ketoconazole 2% shampoo was applied to wet scalp daily from 08/01/25 to 08/05/25. Observation of medication on hand revealed there was an unopened bottle of ketoconazole 2% shampoo dispensed on 09/20/25 available.	C 342		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2025
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C 342	Continued From page 34 Telephone interview with a representative from the facility's contracted pharmacy on 08/05/25 at 2:06pm revealed: -Resident #3 had an order for ketoconazole 2% shampoo every week on Tuesday dated 09/20/25. -The pharmacy dispensed on bottle of ketoconazole shampoo on 09/20/25. Interview with the MA on 08/05/25 at 10:05am revealed: -She refused her shampoo. -She documented on the MAR wrong. Interview with the Administrator on 08/06/25 at 3:39pm revealed: -She expected the documentation on the MARs to be accurate. -The information on the MAR should be accurate when the PCP reviewed the MAR.	C 342		
C 347	10A NCAC 13G .1004 (o) Medication Administration 10A NCAC 13G .1004 Medication Administration (o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and that the borrowing and replacement of the medication shall be documented. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that medications were not being shared except for	C 347		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 08/06/2025
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C 347	Continued From page 35 emergencies for 2 of 2 sampled residents (#1 and #2). The findings are: 1. Review of Resident #1's current FL-2 dated 01/08/25 revealed diagnoses included cerebral anoxic injury, schizoaffective disorder, diabetes mellitus type 2, and osteoarthritis. Review of Resident 1's signed physician order dated 02/18/25 revealed there was an order for polyethylene glycol (used to treat constipation) 17gms daily. Review of Resident #1's June 2025 medication administration record (MAR) revealed: -There was an entry for polyethylene glycol 17gms in 8 ounces of liquid daily with a scheduled administration time of 8:00am. -There was documentation polyethylene glycol was administered every morning from 06/1/25 to 06/30/25. Review of Resident #1's July 2025 MAR revealed: -There was an entry for polyethylene glycol 17gms in 8 ounces of liquid daily with a scheduled administration time of 8:00am. -There was documentation polyethylene glycol was administered every morning from 07/1/25 to 07/31/25. Review of Resident #1's August 2025 MAR from 08/01/25 to 08/05/25 revealed: -There was an entry for polyethylene glycol 17gms in 8 ounces of liquid daily with a scheduled administration time of 8:00am. -There was documentation polyethylene glycol was administered every morning from 08/1/25 to 08/05/25.	C 347			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2025
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C 347	Continued From page 36 Observation of Resident #1's medications on hand on 08/05/25 at 10:30am revealed there was a 510ml bottle of polyethylene glycol that was ½ full dispensed on 02/18/25. Telephone interview with a representative from the facility's contracted pharmacy on 08/05/25 at 2:06pm revealed: -Resident #1 had an order for polyethylene glycol 17gms daily dated 02/18/25. -The pharmacy dispensed a 510ml bottle of polyethylene glycol on 02/18/25, which would last 30 days. -This was the only dispensing of polyethylene glycol for Resident #1. Interview with Resident #1 on 08/05/25 at 3:29pm revealed: -She took polyethylene glycol every morning at breakfast. -The MA put the medication in a cup of water. -She had taken polyethylene for years for constipation. Refer to the interview with the medication aide (MA) on 08/05/25 at 10:05am. Refer to the telephone interview with the Administrator on 08/06/25 at 3:39pm. 2. Review of Resident #2's current FL-2 dated 12/03/24 revealed: -Diagnoses included schizoaffective disorder, toxic metabolic encephalopathy, and borderline personality disorder. -There was an order for polyethylene glycol 17gms (used to treat constipation) daily. Review of Resident #2's June 2025 medication	C 347		

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C 347	Continued From page 37 administration record (MAR) revealed: -There was an entry for polyethylene glycol 17gms in 8 ounces of liquid daily with a scheduled administration time of 8:00am. -There was documentation polyethylene glycol was administered every morning from 06/1/25 to 06/30/25. Review of Resident #2's July 2025 MAR revealed: -There was an entry for polyethylene glycol 17gms in 8 ounces of liquid daily with a scheduled administration time of 8:00am. -There was documentation polyethylene glycol was administered every morning from 07/1/25 to 07/31/25. Review of Resident #2's August 2025 MAR from 08/01/25 to 08/05/25 revealed: -There was an entry for polyethylene glycol 17gms in 8 ounces of liquid daily with a scheduled administration time of 8:00am. -There was documentation polyethylene glycol was administered every morning from 08/1/25 to 08/05/25. Observation of Resident #2's medications on hand on 08/05/25 at 10:38am revealed there was a 510ml bottle of polyethylene glycol that was 1/4 full. Telephone interview with the pharmacy on 08/05/25 at 2:06pm revealed: -Resident #1 had an order for polyethylene glycol 17gms daily dated 12/04/24. -The pharmacy dispensed a 510ml bottle of polyethylene glycol on 04/03/24, which would last 30 days. Interview with Resident #2 on 08/05/25 at 3:45pm revealed:	C 347		

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C 347	Continued From page 38 -She received polyethylene glycol powder in her coffee each morning. -The MA would pour the powder in her coffee each morning. -She did not notice if the MA used the same bottle to administer the medication to other residents. Refer to the interview with the medication aide (MA) on 08/05/25 at 10:05am. Refer to the telephone interview with the Administrator on 08/06/25 at 3:39pm. Interview with the MA on 08/05/25 at 10:05am revealed: -She administered polyethylene glycol to several residents each morning during breakfast. -She would take one bottle of polyethylene glycol from the medication room to the dining room. -During breakfast she would dispense a capful of powder from the same bottle of polyethylene glycol in each resident's cup of water that had an order for polyethylene glycol. -It was easier to bring one bottle of medication to the dining room table instead of multiple bottles. -Once one bottle was empty she would use another residents bottle of polyethylene and reorder to replace the empty bottle. Telephone interview with the Administrator on 08/06/25 at 3:39pm revealed: -Each resident should have their own medication. -The residents should not give out of medication. -The MAs should order medications timely so the medication would not give out. -There was no reason medication should be shared among residents. -Each resident paid for their medication and she expected the residents to take their own medication.	C 347		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2025
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C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 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 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, interviews, and record reviews, the facility failed to ensure readily retrievable record that accurately reconciled the receipt, disposition, and administration of controlled substances for 1 of 1 sampled residents (#2) related to a seizure medication, a pain medication and a medication for anxiety (#2). The findings are: Review of Resident #2's current FL-2 dated 12/03/24 revealed diagnoses included schizophrenia disorder, bipolar disorder, borderline personality disorder, and toxic metabolic encephalopathy. 1. Review of Resident #2's signed physician's order dated 07/29/25 revealed there was an order for lorazepam 1mg (used to treat anxiety) three times daily. Review of Resident #2's July 2025 medication administration record (MAR) from 07/29/25 to 07/30/25 revealed: -There was an entry for lorazepam 1mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm.	C 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2025
NAME OF PROVIDER OR SUPPLIER ABOVE AND BEYOND FAMILY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 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 367	Continued From page 40 -There was documentation lorazepam was administered three times daily on 07/29/25 and 07/30/25 and twice daily on 07/31/25. -The MAR was blank on 07/31/25 at 8:00pm. Review of Resident #2's August 2025 MAR 08/01/25 to 08/05/25 revealed: -There was an entry for lorazepam 1mg three times daily with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation lorazepam 1mg was administered three times daily from 08/01/25 to 08/04/25 and twice on 08/05/25. Observation of Resident #2's medications on hand on 08/05/25 at 11:48am revealed there was a punch card with 17 of 90 lorazepam 1mg tablets remaining with a dispensed date of 07/09/25. Review of Resident #2's controlled substance count sheet (CSCS) date 07/09/25 revealed: -There was a CSCS dated 07/09/25 for lorazepam 1mg tablet twice daily and one tablet as needed for anxiety. -The prescription label attached to the CSCS read, "90 of 90 lorazepam 1mg tablets dispensed on 07/09/25. -There was documentation that 90 lorazepam 1mg tablets were received on 07/09/25. -There was no documentation of lorazepam 1mg signed out on 07/19/25. -On 07/31/25 at 8:00am the beginning quantity for lorazepam 1mg was 32. -There was documentation that lorazepam 1mg was signed out for administration on 07/31/25 at 8:00am, with a remaining balance of 51. -There was documentation that 16 lorazepam 1mg had been administered from 07/31/25 at 12:00pm to 08/05/25 at 12:00pm with a remaining	C 367		

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C 367	Continued From page 41 balance of 35. Based on observation and review of Resident #2's CSCS and medication on hand for lorazepam 1mg it was determine that the documentation on the CSCS countdown sheet was incorrect. Telephone interview with a second MA on 08/06/25 at 10:02am revealed: -She administered lorazepam to Resident #2. -She realized the CSCS did not match the number of tablets remaining for Resident #2's lorazepam. -She told the first shift MA that the count was incorrect and that she needed to fix it. -She knew the count was still incorrect but she had signed out for the lorazepam that she had administered. -She had not notified anyone else that the CSCS was incorrect. Refer to the interview with the MA on 08/05/25 at 10:05am. Refer to the interview with the Administrator on 08/06/25 at 3:39pm. 2. Review of Resident #2's signed physician's order dated 05/08/25 revealed there was an order for pregabalin 200mg (used to treat seizures) three times daily. Review of Resident #2's July 2025 medication administration record (MAR) from 07/21/25 to 07/31/25 revealed: -There was an entry for pregabalin 200mg three times daily with a scheduled administration time of 8:00am, 12:00pm and 8:00pm. -There was documentation pregabalin was	C 367		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001177	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/06/2025
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C 367	Continued From page 42 administered three times daily from 07/21/25 to 07/30/25 and 07/31/25 at 8:00am. -The MAR was blank on 07/31/25 at 12:00pm and 8:00pm. Review of Resident #2's August 2025 MAR from 08/01/25 to 08/05/25 revealed: -There was an entry for pregabalin 200mg three times daily with a scheduled administration time of 8:00am, 12:00pm and 8:00pm. -There was documentation pregabalin was administered three times daily from 08/01/25 to 08/04/25 and at 8:00am and 12:00pm. Observation of Resident #2's medications on hand on 08/05/25 at 11:48am revealed there was a punch card with 47 of 60 of pregabalin tablets remaining with a dispensed date of 07/21/25. Review of Resident #2's controlled substance count sheet (CSCS) date 07/21/25 revealed: -There was a CSCS dated 07/21/25 for pregabalin 200mg take 1 capsule three times daily. -The prescription label attached to the CSCS read, "card 2 of 2 containing 60 of 90 pregabalin 200mg dispensed on 07/21/25. -The first entry was on 07/31/25 at 8:00pm of 1 capsule signed out for administration, with a remaining count of 59 capsules. -There was no entry of the controlled substance being received. -There was an entry for 08/01/25 at 8:00am, 12:00pm, and 8:00pm. -There was an entry for 08/02/25 at 8:00am, 12:00pm, and 8:00pm. -There was an entry for 08/03/25 at 8:00am, 12:00pm, and 8:00pm. -There was an entry for 08/04/25 at 8:00am, 12:00pm, and 8:00pm.	C 367		

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C 367	Continued From page 43 -There was an entry for 08/05/25 at 8:00am and 12:00pm. -The remaining count on the CSCS was 45. Based on observation and review of Resident #2's CSCS for pregabalin 200mg and medication on hand it was determine that there were 2 extra pregabalin 200mg tablets remaining. Telephone interview with a second medication aide (MA) on 08/06/25 at 10:02am revealed: -She had not noticed the CSCS for pregabalin was incorrect. -She told the first shift MA that the count was incorrect and that she needed to fix it. -She knew the count was still incorrect but she had signed out for the pregabalin that she had administered. -She had not notified anyone else that the CSCS was incorrect. Refer to the interview with the MA on 08/05/25 at 10:05am. Refer to the interview with the Administrator on 08/06/25 at 3:39pm. 3. Review of Resident #2's signed physician's order dated 07/03/25 revealed there was an order for tramadol 100mg (used to treat pain) three times daily. Review of Resident #2's August 2025 medication administration record (MAR) from 08/03/25 to 08/05/25 revealed: -There was an entry tramadol 50mg give 2 tablets every 8 hours with a scheduled administration time of 8:00am, 4:00pm, and 8:00pm. -There was documentation that tramadol was administered from 08/03/25 at 4:00pm to	C 367		

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C 367	Continued From page 44 08/05/25 at 8:00am. Observation of Resident #2's medications on hand on 08/05/25 at 11:49am revealed there was a punch card with 46 of 60 tramadol 50mg tablets remaining with a dispensed date of 07/25/25. Review of Resident #2's controlled substance count sheet (CSCS) date 07/25/25 revealed: -There was a CSCS dated 07/25/25 for Tramadol 50mg 2 tablets every 8 hours. -The prescription label attached to the CSCS read, "card 3 of 3 with 60 Tramadol 50mg tablets dispensed on 07/09/25. -There was documentation that 60 Tramadol 50mg tablets were received in card 3 on 08/03/25 -There were 12 Tramadol 50mg tablets signed out from 08/03/25 to 08/05/25 with 48 tablets remaining. Based on observation and review of Resident #2's CSCS for tramadol 50mg and medication on hand it was determine that there were 2 tramadol 50mg tablets missing. Telephone interview with a second MA on 08/06/25 at 10:02am revealed: -She had not noticed the count for Tramadol was off. -She counted controlled substances with the on coming/off going MA each shift. -The incorrect count of the CSCS should have been noticed. Refer to the interview with the MA on 08/05/25 at 10:05am. Refer to the interview with the Administrator on 08/06/25 at 3:39pm.	C 367			

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C 367	Continued From page 45 Interview with the MA on 08/05/25 at 10:05am revealed: -She did not know why the CSCS did not match the number of pills in the punch card. -She signed the CSCS when she popped the medication to administer, but she did not pay attention to the number of the pills in the punch card compared to the number of pills documented on the CSCS. -She did not count controlled substances with anyone. -The MAs should count controlled substances and we would not have the mess we have now. Interview with the Administrator on 08/06/25 at 3:39pm revealed: -She expected the MAs to document on the CSCS each time a controlled substance was popped from the punch card. -She expected the MAs to count controlled substances when the shift changed. -If there was a discrepancy when the controlled substances were counted, the problem with the count should be corrected before the MA leaves the shift.	C 367		