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 _____	R 10/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 10/29/25.	{C 000}		
{C 148}	10A NCAC 13G .0406 (a)(8) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 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) on 09/26/25. -There was no documentation that a controlled substance screening had been completed prior to the hire date. Interview with the MA on 10/29/25 at 12:40pm revealed: -She was hired as a MA the last week of September 2025. -She had a controlled substance screening completed the day she was hired. -Someone who worked for the facility did the	{C 148}		

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 _____	R 10/29/2025

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{C 148}	Continued From page 1 controlled substance screening, but she did not know her title. -She did not know why the controlled substance screening was not in her personnel folder. Interview with the owner on 10/29/25 at 11:30am revealed: -Staff B had the controlled substance screening done when she was hired. -The results of the controlled substance screening should be in Staff B's personnel record. -She did not know why the results of the controlled substance screening was not in the MAs personnel record. -She did not know who audited the personnel records for completion. Attempted telephone interview with the Administrator on 10/29/25 at 12:35pm was unsuccessful. Prior to the survey exit on 10/29/25, a copy of Staff B's controlled substance screening was not provided.	{C 148}		
{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.	{C 315}		

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	FCL001177	A. BUILDING: _____ B. WING _____	R 10/29/2025

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

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{C 315}	Continued From page 2 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 1 of 3 sampled residents (#3) related to medication for pain and depression (#3). The findings are: 1. Review of Resident #3's current FL-2 dated 09/26/25 revealed diagnoses included acute cholecystitis, altered mental status, dementia, and hyperlipidemia. a. Review of Resident #3's current FL-2 dated 09/26/25 revealed there was an order for gabapentin 100mg (used to treat pain) three times daily. Review of Resident #3's signed physician order dated 04/01/25 revealed there was an order for gabapentin 100mg in the morning and midday and 200mg at bedtime. Review of Resident #3's September 2025 medication administration record (MAR) revealed: -There was an entry for gabapentin 100mg twice daily with a scheduled administration time of 8:00am and 12:00pm. -There was documentation gabapentin 100mg was administered at 8:00am and 12:00pm from 09/01/25 to 09/26/25 and 09/30/25; the MAR was blank from 09/27/25 to 09/28/25. -There was an entry for gabapentin 100mg tablets take two tablets at bedtime with a	{C 315}		

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	FCL001177	A. BUILDING: _____ B. WING _____	R 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{C 315}	Continued From page 3	{C 315}		

scheduled administration time of 8:00pm.
-There was documentation gabapentin 100mg two tablets were administered at 8:00pm from 09/01/25 to 09/26/25; the MAR was blank from 09/26/25 to 09/30/25.

Review of Resident #3's October 2025 MAR from 10/01/25 to 10/28/25 revealed:
-There was an entry for gabapentin 100mg at twice daily with a scheduled administration time of 8:00am and 12:00pm.
-There was documentation gabapentin 100mg was administered at 8:00am and 12:00pm from 10/01/25 to 10/28/25.
-There was an entry for gabapentin 100mg tablets take two tablets at bedtime with a scheduled administration time of 8:00pm.
-There was documentation gabapentin 100mg two tablets were administered at 8:00pm from 10/01/25 to 10/28/25.

Observation of Resident #3's medication on hand on 10/29/25 at 11:00am revealed:
-There was a punch card with 19 of 60 gabapentin 100mg capsules to be administered twice daily in the morning and at midday dispensed on 09/27/25.
-There was a second punch card with 6 of 60 gabapentin 100mg capsules take two capsules at bedtime dispensed on 09/27/25.

Telephone interview with the facility's contracted pharmacy on 10/29/25 at 12:02pm revealed:
-Resident #3 had an order for gabapentin 100mg twice daily in the morning and midday and 200mg in the evening dated 04/01/25.
-The pharmacy dispensed 120 gabapentin 100 mg capsules on 08/26/25, 09/24/25, and 10/25/25, for a 30 day supply.
-The pharmacy did not have an order gabapentin

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

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{C 315}	Continued From page 4 100mg three times daily dated 09/26/25. Telephone interview with a representative from the PCP's office on 10/29/25 at 12:16pm revealed: -No one from the facility had contacted the PCP's office to clarify gabapentin 100mg. -Resident #3's current order for gabapentin was 100mg one capsule in the morning and at midday and two capsules in the evening. Attempted telephone interview with the Administrator on 10/29/25 at 12:35pm was unsuccessful. Refer to the telephone interview with the facility's contracted pharmacy on 10/29/25 at 12:02pm. Refer to the interview with a MA on 10/29/25 at 11:10am. Refer to the interview with the Owner on 10/29/25 at 11:30am. b. Review of Resident #3's current FL-2 dated 09/26/25 revealed there was an order for trazodone 50mg (used to treat depression) at bedtime. Review of Resident #3's signed physician orders dated 04/01/25 revealed there was an order for trazodone 50mg take 1/2 tablet every morning and 1.5 tablets at bedtime. Review of Resident #3's September 2025 medication administration record (MAR) revealed: -There was an entry for trazodone 50mg ½ tablet every morning with a scheduled administration time of 8:00am. -Three was documentation trazodone 50mg 1/2	{C 315}		

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 _____	R 10/29/2025

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

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{C 315}	Continued From page 5	{C 315}		

tablet was administered at 8:00am from 09/01/25 to 09/26/25 and 09/30/25; the MAR was blank from 09/27/25 to 09/29/25.
-There was an entry for trazodone 50mg 1.5 tablets at bedtime with a scheduled administration time of 8:00pm.
-There was documentation trazodone 50mg mg 1.5 tablets were administed at 8:00pm from 09/01/25 to 09/26/25; the MAR was blank from 09/27/25 to 09/30/25.

Review of Resident #3's October 2025 MAR from 10/01/25 to 10/28/25 revealed:
-There was an entry for trazodone 50mg ½ tablet every morning with a scheduled administration time of 8:00am.
-There was documentation trazodone 50mg 1/2 tablet was administered at 8:00am from 10/01/25 to 10/28/25,
-There was an entry for trazodone 50mg 1.5 tablets at bedtime with a scheduled administration time of 8:00pm.
-There was documentation trazodone 50mg mg 1.5 tablets were administered at 8:00pm from 10/01/25 to 10/28/25.

Observation of Resident #3's medication on hand on 10/29/25 at 11:00am revealed:
-There was a punch card with 2 of 15 half tablets of trazodone 50mg 1/2 to be administered twice daily in the morning and at midday dispensed on 09/27/25.
-There was a second punch card with 6 of 45 trazodone 50mg 1.5 tablets take two tablets at bedtime dispensed on 09/27/25.

Telephone interview with the facility's contracted pharmacy on 10/29/25 at 12:02pm revealed:
-Resident #3 had an order for trazodone 50mg ½ tablet every morning and 1.5 tablets in the

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 _____	R 10/29/2025

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

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{C 315}	Continued From page 6	{C 315}		

evening dated 04/01/25.
-The pharmacy dispensed 60 trazodone 50mg tablets on 08/26/25, 09/24/25, and 10/25/25, for a 30 day supply.
-The pharmacy did not have an order for trazodone 50mg every evening

Telephone interview with a representative from the PCP's office on 10/29/25 at 12:16pm revealed:
-No one from the facility had contacted the PCP's office to clarify trazodone 50mg.
-Resident #3's current order for trazodone 50mg ½ tablet in the morning and 1.5 tablets at bedtime.

Attempted telephone interview with the Administrator on 10/29/25 at 12:35pm was unsuccessful.

Refer to the telephone interview with the facility's contracted pharmacy on 10/29/25 at 12:02pm.

Refer to the interview with a MA on 10/29/25 at 11:10am.

Refer to the interview with the Owner on 10/29/25 at 11:30am.

_____
Telephone interview with the facility's contracted pharmacy on 10/29/25 at 12:02pm revealed:
-The pharmacy did receive a copy of the FL-2 dated 09/26/25.
-If the pharmacy had received the FL-2, all discrepancies related to the medications would have been clarified by calling the PCP.

Interview with a MA on 10/29/25 at 11:10am revealed:
-She did not recall faxing the FL-2 dated 09/26/25

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

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{C 315}	Continued From page 7 to the pharmacy. -She should have faxed the FL-2 to the pharmacy. -She did not review the FL-2 and compare the medications to the current MAR. -She was not sure who was responsible for comparing medications on the FL-2 to the current MAR. Interview with the Owner on 10/29/25 at 11:30am revealed: -The new FL-2 dated 09/26/25 would be faxed to the pharmacy for the pharmacy to review for accuracy. -The MAs should compare the medications on the FL-2 with the medications listed on the MAR to ensure they were the same. -The PCP should be notified of any discrepancies noted between the FL-2 and the MAR. -The pharmacy was responsible for clarifying any discrepancies between the FL-2 and the MAR. -She did not know the pharmacy did not receive a copy of the FL-2 dated 09/26/25.	{C 315}		
{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	{C 342}		

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 _____	R 10/29/2025

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

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{C 342}	Continued From page 8	{C 342}		

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 mediation administration records (MAR) were accurate for 1 of 3 sampled residents (#2) including a cream for fungal infections and two eye drops (#2).

The findings are:

Review of Resident #2's current FL-2 dated 07/30/25 revealed diagnoses included syncope, falls, heart failure, osteoarthritis, and atrial fibrillation.

1. Review of Resident #2's signed physician's order dated 09/27/25 revealed there was an order for clotrimazole cream 1% (used to treat fungal infections) apply between toes twice daily.

Review of Resident #2's September 2025 medication administration record (MAR) from 09/27/25 to 09/30/25 revealed:
-There was an entry for clotrimazole cream 1% apply between toes twice daily with no scheduled administration time.
-There was documentation that clotrimazole cream was applied between toes once a day from

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	FCL001177	A. BUILDING: _____ B. WING _____	R 10/29/2025

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

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{C 342}	Continued From page 9 09/27/25 to 09/29/25. -There was no other documentation on the MAR for the clotrimazole cream entry. Attempted telephone interview with the Administrator on 10/29/25 at 12:35pm was unsuccessful. Refer to the interview with a MA on 10/29/25 at 12:40pm. Refer to the interview with the Owner on 10/29/25 at 11:30am. 2. Review of Resident #2's signed physician's order dated 08/11/25 revealed there was an order for brimonidine 0.2% eye drops (used to lower the eye pressure) instill one drop into each eye twice daily. Review of Resident #2's September 2025 MAR revealed: -There was an entry for brimonidine 0.2% eye drops instill one drop into each eye twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation that brimonidine eye drops were administered twice daily from 09/01/25 to 09/17/25, on 09/19/25. -There was no documentation brimonidine eye drops were administered twice daily on 09/18/25 and from 09/20/25 to 09/30/25; the MAR was blank. Attempted telephone interview with the Administrator on 10/29/25 at 12:35pm was unsuccessful. Refer to the interview with a MA on 10/29/25 at 12:40pm.	{C 342}		

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 _____	R 10/29/2025

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

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{C 342}	Continued From page 10 Refer to the interview with the Owner on 10/29/25 at 11:30am. 3. Review of Resident #2's signed physician's order dated 07/31/25 revealed there was an order for latanoprost 0.005% eye drops (used to lower the pressure inside the eye) instill one drop into each eye at bedtime. Review of Resident #2's September 2025 MAR revealed: -There was an entry for latanoprost 0.005% eye drops instill one drop into each eye at bedtime with a scheduled administration time of 8:00pm. -There was documentation that latanoprost eye drops were administered each night from 09/01/25 to 09/24/25. -There was no documentation that latanoprost eye drops were administered each night from 09/25/25 to 09/30/25; the MAR was blank. Attempted telephone interview with the Administrator on 10/29/25 at 12:35pm was unsuccessful. Refer to the interview with a MA on 10/29/25 at 12:40pm. Refer to the interview with the Owner on 10/29/25 at 11:30am. _____ Interview with a MA on 10/29/25 at 12:40pm revealed: -She was hired as a MA the last week of September 2025. -She always checked the MARs to ensure she had documented all the medications she had administered. -If she saw blanks on the MAR, she would tell the	{C 342}		

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 _____	R 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{C 342}	Continued From page 11 other MAs, to see if the medication was given and why the MAR was not signed. -Sometimes there were blanks on the MAR, possibly due to oversight. Interview with the Owner on 10/29/25 at 11:30am revealed: -A representative from the pharmacy was responsible for auditing the MARs for accuracy. -The facility sent the MARs to the pharmacy every 3 months to ensure the MARs were accurate. -The on-coming MA should look over the off-going MAs documentation to ensure the MAR was accurate. -She did not know if anyone from the facility audited the MARS.	{C 342}		