Division of Health Service Regulation

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}	Staff B hire date was 10/6/2025. She had a urine drug screen performed by the Pharmacy SN. Upon the follow up survey the results could not be found in her personnel file. Apparently the sealed controlled substance screening envelope and recorded results with the SN name, license number, date and results could not be found. Immediate Correction Action: A repeat controlled substance screening was performed the following day by the same pharmacy SN and placed immediately into Staff B's personnel file. The file has been audited and it is complete.	
{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}	Area of Non-Compliance: Staff examination and screening for the presence of controlled substances 1. Identification of the Issue: It was noted that the facility did not have consistent or documented procedures to ensure that all staff members receive appropriate examination and screening for the presence of controlled substances as required by regulatory standards. 2. Immediate Corrective Action: • Effective immediately, all current staff members who have not completed a drug screen will undergo a controlled substance screening using a onsite rapid drug screen or designed laboratory provider according to drug screening policies. • Any staff member who does not complete screening within the required timeframe will be removed from the schedule until compliance is verified. • Documentation of completed	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Stej Patterson TITLE owner (X6) DATE 11/22/2025

Reviewed and Acknowledged 12/22/25 JT

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 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}	screenings will be placed in each employee's personnel file. 3. Preventive Measures: To prevent recurrence of this deficiency, the following actions will be implemented: • The Administrator or designated HR staff will maintain a Drug Screening Compliance Log to ensure timely completion and tracking for all employees. • All new hires will be screened prior to starting work, and employment will be contingent upon a negative test result. • Supervisors will receive training on recognizing signs of impairment and the proper procedure for initiating reasonable suspicion testing. screenings will be placed in each employee's personnel file. 3. Preventive Measures: To prevent recurrence of this deficiency, the following actions will be implemented: • The Administrator or designated HR staff will maintain a Drug Screening Compliance Log to ensure timely completion and tracking for all employees. • All new hires will be screened prior to starting work, and employment will be contingent upon a negative test result. • Supervisors will receive training on recognizing signs of impairment and the proper procedure for initiating reasonable suspicion testing. 4. Monitoring & Quality Assurance: • The Administrator or designee will conduct monthly audits of the personnel files to ensure that drug screening documentation is current and complete. • Any missed or delayed screenings identified during the audit will be	
{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}		

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 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}	corrected within 24 hours.• Audit results will be reviewed quarterly during staff meetings to reinforce compliance expectations. 5. Responsible Party: The Administrator will be responsible for overseeing policy implementation, scheduling screenings, and ensuring ongoing compliance with controlled-substance testing requirements. 6. Completion Date: Full implementation of this plan, including completion of testing for all current staff and adoption of the Drug Screening Policy, will be completed by 11/19/2025. C 315 Plan of Correction Area of Non-Compliance: Failure to clarify medication orders 1. Identification of the Issue: It was cited that the facility did not clarify medication orders that were incomplete, unclear, or inconsistent. This lack of clarification created a risk for medication errors and improper administration. 2. Immediate Corrective Action Taken: • The unclear medication orders identified during the survey were immediately reviewed and clarified with the prescribing healthcare provider. • Updated, corrected orders were obtained in writing and placed in the resident's chart and the Medication Administration Record (MAR). • Staff responsible for administering medications were notified of the corrected orders to ensure accurate	

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 315}	Continued From page 3 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	{C 315}	implementation. • A full review of all current resident medication orders and MARs was conducted to identify and correct any additional discrepancies. 3. Preventive Measures to Avoid Recurrence: The following steps will be put in place to prevent unclear orders from being used: • A Medication Order Clarification Protocol will be implemented, requiring staff to: o Immediately contact the prescribing practitioner for any order that is incomplete, illegible, contradictory, missing dosage/frequency, or otherwise unclear. o Document every clarification request, including date, time, staff initials, and physician response. • No medication order will be entered into the MAR or administered until clarification is received. • Nursing/medication staff will receive mandatory in-service training on identifying unclear orders, proper documentation, and the new clarification protocol. The facility will utilize a standardized Medication Order Verification Form to ensure accuracy and completeness before orders are transcribed or administered. 4. Monitoring and Quality Assurance: • The Administrator or Medication Supervisor will conduct bi- weekly audits of medication orders and MARs for the next 60 days, then monthly thereafter.	

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 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}	Any discrepancies found during audits will be corrected within 24 hours and addressed with the responsible staff member. • Audit results will be reviewed during monthly staff meetings, and additional training will be provided if patterns of non-compliance are identified. 5. Responsible Party: The Administrator and Medication Supervisor will be responsible for implementing, monitoring, and maintaining compliance with this Plan of Correction. 6. Completion Date: All corrective actions, staff training, and implementation of the Medication Order Clarification Protocol will be completed by 11/17/2025. Resident #3's MAR was found to be blank from 9/27/25 to 9/28/2025. Resident #3 was admitted to the hospital the eve of 9/26/2025 and was discharged the morning of 9/29/2026. Immediate corrrection action: All MA's have been educated: The MAR's should be signed with an H for Hold or a / in the column involved. Further documentation will be docu on the back of the MAR stating the reason the dates of 9/27/2025 thru 9/28/2025 were held. The MA's have been educated and received their Certification Of Completion for Medication Administration: 15 Hour Training Course for Adult Care Homes by the Pharmacy RN.	

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 315}	Continued From page 5 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	{C 315}	Resident#3 was discharged from the hospital 9/29/2025 was prepared by the hospital LCSW. The medication (Gabapentin) orders did not match the previous orders on the MAR. Immediate Action: Staff have been educated to compare the FL2 and discharge orders from the hospital to the current MAR upon admission back to the facility and notify PCP for clarification of any discrepancies. After receiving clarification documentation from the PCP the orders will be faxed to the pharmacy. A current updated FL2 has been obtained from the PCP clarifying the Gabapentin order.	

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 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

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 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}	Plan of Correction Area of Non-Compliance: Inaccurate medication records 1. Identification of the Issue: During the survey, it was identified that the facility did not maintain accurate medication records, including incomplete documentation, missed signatures, and inconsistencies between physician orders and the Medication Administration Record (MAR). This created potential risk for medication errors and compromised resident safety. 2. Immediate Corrective Action Taken:	

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 342}	Continued From page 8 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	{C 342}	• All medication records identified as inaccurate were immediately reviewed and corrected. • Staff were interviewed to verify medication administration, and missing documentation was corrected based on confirmed information. • Current physician orders were compared to each resident's MAR to ensure full accuracy and alignment. • Any discrepancies were immediately reconciled with updated MAR entries and proper documentation. • Residents and families were notified as appropriate when clarification was needed. 3. Measures to Prevent Recurrence: The following actions will be implemented to ensure medication records remain accurate: • A Medication Record Accuracy Protocol will be adopted, requiring: o Verification of all new medication orders before entry into the MAR. o Double-checking MAR updates by the Administrator or Medication Supervisor. o Immediate documentation after each medication pass—no delayed charting. • Medication staff will receive mandatory in-service training on: o Accurate MAR documentation o Correcting errors using proper correction procedures on Matching medication orders with MAR entries o Importance of real-time documentation • A standardized Daily MAR Review Checklist will be used at the end of each shift to confirm that: o All medications have been signed for	

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 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}	o Any missed signatures are corrected before shift-end o No unexplained gaps exist 4. Monitoring and Quality Assurance: • The Administrator or Medication Supervisor will perform bi- weekly MAR audits for 60 days, then quarterly audits thereafter. • Any incomplete or inaccurate entries found during audits will be corrected within 24 hours and addressed with the responsible staff. • Patterns of errors will trigger immediate retraining or corrective action. • Audit findings will be reviewed during monthly staff meetings to reinforce expectations and identify areas for further improvement. 5. Responsible Party: The Administrator will be responsible for implementation, monitoring, and ongoing oversight of medication record accuracy. Completion Date: 11/18/2025. MA's have been educated to place a H or / in the column if medications are not available and document on the bck of the medication is not available (9/25/025 - 9/30/2025). The eye doctor would not re order Resident #2's eye drops until Resident #2 was seen in their office for a visit and eye injection. The medication was received after that visit.	

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 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
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 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}		