STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001139	A. BUILDING: _____ B. WING _____	04/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE AND BEYOND FAMILY CARE II	316 DENNY CIRCLE GRAHAM, NC 27253

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an initial survey and complaint investigation on 04/01/19, due to the facility's failure to renew their license on or before 12/31/2018. The Alamance County Department of Social Services initiated the complaint investigation on 03/25/19.	C 000		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure the building was equipped and maintained for 1 of 3 sampled residents (#3) residing in the facility who had physical and cognitive impairments and was unable to evacuate independently. The findings are: Review of the facility's license with an effective date of 01/25/19 revealed the facility was licensed for a capacity of 6 ambulatory residents. Observation during the initial tour of the facility on 03/28/19 between 9:15 and 9:30 revealed a census of 4 residents.	C 022		

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Review of Resident #3's current FL2 dated 01/20/19 revealed:
-Diagnoses included dementia, muscle weakness, and difficulty walking.
-Resident #3 was semi-ambulatory.
-There was no information regarding orientation.

Review of Resident #3's care plan dated 12/11/18 revealed:
-Resident #3 was ambulatory with an aide or device, but the care plan did not indicate the type of device.
-Resident #3 was forgetful and needed reminders.
-Resident #3 was totally dependent with toileting, dressing, and grooming,
-Resident #3 needed supervision with ambulating and transfers.

Observation of Resident #3 on 03/28/19 at 1:33 pm revealed:
-Facility staff brought a walker to where Resident #3 was seated in the kitchen.
-Facility staff held the walker while Resident #3 attempted to stand three times by attempting to rock to a standing position.
-After three failed attempts to stand independently, the staff placed her hand under Resident #3's arm and assisted her to a standing position.
-Resident #3 required verbal direction to ambulate from the kitchen to the living room common area.

Observation of a fire drill conducted by the Supervisor-in-Charge (SIC) on 03/29/19 at 10:24 am revealed:
-Four residents were seated in the living room common area.
-The fire alarm sounded and the SIC made the

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announcement it was a fire drill to residents.
-The SIC placed Resident #3's walker in front of her and told her to "get up and come on" while motioning with her hands for the Resident #3 to walk from the living room common area.
-Resident #3 scooted to the edge of her seat, stood up and walked into the hallway.
-The SIC instructed Resident #3 to go outside and pointed to the exit door.
-The fire drill began at 10:24 am and ended at 10:27 am.

Observation of a second fire drill conducted by the SIC on 03/29/19 at 6:15 pm revealed:
-Resident #3 was sitting in the living room common area alone and the other three residents were in their rooms.
-The SIC placed a walker in front of Resident #3 where she was seated.
-The fire alarm sounded, but the SIC did not announce there was a fire drill nor did she give any verbal prompts to Resident #3.
-When the alarm sounded, Resident #3 continued to sit in a chair in the living room common area and looked out into the hallway.
-Another resident was coming down the hallway when the alarm sounded and went into the living room common area to assist Resident #3.
-The other resident held Resident #3's walker and yelled to Resident #3 "Come on! Get up and come on!"
-Resident #3 scooted to the edge of her seat and attempted to rock in the seat to get up, but was unable to do so.
-The other resident grabbed Resident #3's hand and assisted her to a standing position and then the other resident held onto the front of Resident #3's walker to guide her to the exit door.
-The fire drill began at 6:15 pm and ended at 6:20 pm.

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C 022	Continued From page 3 Interview with the SIC on 03/28/19 at 10:31 am revealed Resident #3 did not comprehend well and she did not talk much. Interview with the SIC on 03/29/19 at 2:04 pm revealed: -She performed fire drills two or three times a week although they were only required to be performed once a month. -She always put Resident #3's walker in front of her when she sat down in the chair in the living room common area. -She typically had to verbally prompt Resident #3 three or four times during a fire drill. -Resident #3 usually needed physical assistance with getting up and out of chairs, but sometimes Resident #3 could get up by herself. -When she physically assisted Resident #3, she placed her arm under Resident #3's arm to assist her up. -During fire drills other residents usually verbally prompted Resident #3 by telling her to "come on." -"She might and might not know to get up and leave if there was a real fire." -"She has no comprehension." Interview with a second SIC on 04/01/19 at 11:29 am revealed: -Resident #3 could not walk without her walker. -She had to help the resident get out of chairs during her shift by placing her arm around Resident #3's waist or under her arm. -She had to help Resident #3 more when she sat in a soft chair. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.	C 022		

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C 022	Continued From page 4 Attempted telephone interview with Resident #3's responsible party on 04/01/19 at 12:57 pm was unsuccessful. Telephone interview with the Administrator on 04/01/19 at 1:10 pm revealed: -Fire drills were completed monthly. -Resident #3 had trouble understanding, did not talk much, but could follow commands. -Resident #3 needed verbal prompting to complete tasks. -Staff always made sure Resident #3's walker was placed in front of her prior to fire drills and need for ambulation. -Resident #3's might be able to transfer and ambulate independently on one day, but may need assistance on the following day. The facility failed to assure the building was in compliance with the current license for 6 ambulatory residents resulting in 1 of 3 sampled residents (#3) who was admitted with cognitive and physical impairments that impeded the ability to evacuate without assistance and verbal prompts. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/28/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 17, 2019.	C 022		
C 140	10A NCAC 13G .0405(a)(b) Test For Tuberculosis	C 140		

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C 140	Continued From page 5 10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to assure 2 of 5 sampled staff (Staff D and Staff E) were tested for tuberculosis (TB) disease upon hire. The findings are: 1. Review of staff personnel records revealed there was not a personnel record available for Staff D. Attempted telephone interview with Staff D on	C 140		

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C 140	Continued From page 6 03/28/19 at 3:15 pm and 3:47 pm was unsuccessful. Interview with a Supervisor-in-Charge (SIC) on 04/01/19 at 10:32 am revealed: -Staff D started working in the facility last Saturday, 03/23/19 and her sole responsibility was to clean up. -She did not know if Staff D worked as a volunteer or if she was paid. -The Administrator was responsible for ensuring new staff had a TB skin test, but she reminded the Administrator sometimes. -She did not know if Staff D had a TB skin test. Telephone interview with the Administrator on 03/29/19 at 2:26 pm revealed: -She was responsible for maintaining personnel records, scheduling and ensuring staff had a TB skin test completed upon hire. -She usually had the first TB skin test scheduled for staff upon hire and then scheduled the second TB skin test about two weeks later. -She brought Staff D in to clean up at the facility and Staff D was a volunteer. -She had not hired Staff D yet and on 03/23/19 was her first day volunteering in the facility. -Staff D volunteered at the facility on 03/23/19 from 11 am until 9 pm and on 03/24/19 from 11am until 9 pm. -Staff D had not had a TB skin test scheduled for Staff D because she did not know Staff D needed one. 2. Review of staff personnel records revealed there was not a personnel record available for Staff E. Attempted telephone interview with Staff E on 03/29/19 at 12:03 pm was unsuccessful.	C 140		

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C 140	Continued From page 7 Interview with a Supervisor-in-Charge (SIC) on 03/29/19 at 12:05 pm revealed Staff E worked in the facility seven days a week cleaning and doing resident's laundry. Telephone interview with the Administrator on 03/29/19 at 12:24 pm revealed: -She was responsible for maintaining personnel records and ensuring staff had a TB skin test completed upon hire. -She usually had the first TB skin test scheduled for staff upon hire and then scheduled the second TB skin test about two weeks later. -Staff E had been working at the facility for about a year and was hired to clean up and wash residents' clothes. -She did not schedule a TB skin test for Staff E because he "just cleaned up." -She did not think she needed a personnel record for Staff E nor did she think he needed a TB skin test because "We all have people who clean up." -This was the first time she had heard a housekeeper needed a TB skin test or a personnel record. _____ The Administrator failed to ensure all staff had completed a TB skin test upon hire, which placed the residents at increased risk for exposure to tuberculosis disease. This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/29/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 17, 2019.	C 140		

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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 substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure 1 of 5 sampled staff (Staff E) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of staff personnel records revealed there was not a personnel record available for Staff E. Attempted telephone interview with Staff E on 03/29/19 at 12:03 pm was unsuccessful. Telephone interview with the Administrator on 03/29/19 at 12:24 pm revealed: -She was responsible for maintaining personnel records and ensuring staff had a HCPR check completed upon hire. -Staff E had been working at the facility for about a year and was hired to clean up and wash residents' clothes. -She did not have a personnel record and did not complete a HCPR check for Staff E because he "just cleaned up."	C 145		

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C 145	Continued From page 9 -"We all have people who clean up." -This was the first time she had heard a housekeeper needed a HCPR check or a personnel record. _____ The facility failed to assure Staff E had no substantiated findings on the North Carolina Health Care Personnel Registry upon hire which placed the residents at risk of abuse and/or neglect. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/29/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 17, 2019.	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 in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to complete a criminal background check on 1 of 5 sampled staff (Staff E) upon hire. The findings are:	C 147		

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C 147	Continued From page 10 Review of staff personnel records revealed there was not a personnel record available for Staff E. Attempted telephone interview with Staff E on 03/29/19 at 12:03 pm was unsuccessful. Telephone interview with the Administrator on 03/29/19 at 12:24 pm revealed: -She was responsible for maintaining personnel records and ensuring staff had a criminal background check completed upon hire. -Staff E had been working at the facility for about a year and was hired to clean up and wash residents' clothes. -She did not have a personnel record and did not complete a criminal background check for Staff E because he "just cleaned up." -"We all have people who clean up." -This was the first time she had heard a housekeeper needed a criminal background check. _____ The facility failed to assure Staff E had a state-wide criminal background check completed upon hire which resulted in the facility being unaware of any criminal history. The facility's failure of not knowing Staff E's criminal history was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 03/29/19 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 17, 2019.	C 147		

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C 187	Continued From page 11	C 187		
C 187	10A NCAC 13G .0601 (b)(2) Management And Other Staff 10A NCAC 13G .0601 Management And Other Staff (b) At all times there shall be one administrator or supervisor-in-charge who is directly responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions cited in Paragraph (c) of this Rule regarding the occasional absence of the administrator or supervisor-in-charge, one of the following arrangements shall be used: (2) The administrator shall employ a supervisor-in-charge to live in the home or reside within 500 feet of the home with a means of two-way telecommunication with the home at all times. When the supervisor-in-charge does not live in the licensed home, there shall be at least one staff member who lives in the home or one on each shift and the supervisor-in-charge shall be directly responsible for assuring that all required duties are carried out in the home; or This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to assure that at no time was a resident left alone in the home without a	C 187		

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C 187	Continued From page 12 staff member present for 3 of 4 residents (Residents #2 #3 and #4) who had diagnoses including dementia. The findings are: Interview with a Supervisor-in-Charge (SIC) on 03/28/19 at 10:31 am revealed: -When she worked, she was usually the only staff present in the facility. -There had been an incident in the facility on the morning of 03/28/19 where Resident #1 eloped from the facility. -She was assisting another resident with a bath when Resident #1 walked out the main entrance door between 6:30 am and 7:00 am on 03/28/19. -She heard the door alarm when the resident left the facility, but thought it was the housekeeper coming in to work. -She did not know the resident had left the facility until the housekeeper came in yelling that Resident #1 was down the street. -She and the housekeeper left the facility to go get Resident #1 who eloped and the other three residents were left in the facility alone and unsupervised. -As she was leaving the facility, she contacted the Administrator to inform her she was leaving to go get the eloped resident. -She had to walk a block down the street to where the resident was and coaxed her back in the facility. -She did not have any other choice but to leave the residents alone to go get the eloped resident. -When she returned to the home, another staff member was at the facility. -She was out of the facilty for about fifteen minutes and did not know how long the other staff member had been there.	C 187		

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C 187	Continued From page 13 1. Review of Resident #2's current FL2 dated 07/02/18 revealed: -Diagnoses included dementia with behavior disturbance, chronic obstructive pulmonary disease, diabetes, acute encephalopathy, hypoxia, and syncope. -There was documentation Resident #2 was oriented to self and place. -There was documentation Resident #2 was ambulatory. 2. Review of Resident #3's current FL2 dated 01/20/19 revealed: -Diagnoses included dementia, osteoporosis, anxiety, muscle weakness, and difficulty walking. -There was no information regarding Resident #2's orientation. -There was documentation Resident #3 was semi-ambulatory. 3. Review of Resident #4's current FL2 dated 03/14/19 revealed: -Diagnoses included vascular dementia, hyperlipidemia, history of diabetes, and history of hypertension. -There was documentation Resident #4 was intermittently disoriented. -There was documentation Resident #4 was ambulatory. Observation of the street in front of the facility on 03/28/19 between 3:47 pm and 3:50 pm revealed the place where the SIC identified resident eloped to was approximately 0.1 miles (approximately 528 feet and 3 minutes normal walking distance) from the facility according to a global positioning system (GPS). Interview with two residents on 03/29/19 at 11:50 am revealed:	C 187		

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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 187	Continued From page 14 -There was not a staff member in the facility prior to the SIC leaving the facility on 03/28/19. -They thought another staff came in the facility, but did not know when. -They did not know how long the SIC was gone. Telephone interview with the Administrator on 04/01/19 at 1:10 pm revealed: -She received a call from the SIC on 03/28/19 indicating a resident had eloped and she sent a staff to the facility to be with the other residents until the SIC returned. -She did not know the SIC had left the residents unattended and alone. -She thought the other staff had arrived at the facility prior to the SIC leaving to get the eloped resident. -Residents should not have been left alone and unsupervised. The facility failed to assure staff were present in the facility at all times to provide supervision for three residents (#2, #3, and #4) with diagnoses including dementia resulting in the residents being left alone while staff left the facility to bring a resident (#1) who had eloped back to the facility. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/01/19 for this violation. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MAY 17, 2019.	C 187		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001139	A. BUILDING: _____ B. WING _____	04/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE AND BEYOND FAMILY CARE II	316 DENNY CIRCLE GRAHAM, NC 27253

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C 202	Continued From page 15	C 202		
C 202	10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 3 sampled residents (#2) was tested for tuberculosis (TB) disease upon admission. The findings are: Review of Resident #2's current FL2 dated 07/02/18 revealed diagnoses included acute encephalopathy, hypoxia, syncope, dementia with behavior disturbance, chronic obstructive pulmonary disease, and diabetes. Review of Resident #2's Resident Register revealed an admission date of 11/16/16. Review of Resident #2's record revealed: -There was documentation of a TB skin test placed on 01/20/16 and read as negative on 11/23/16. -There was no documentation of a second TB skin test.	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001139	A. BUILDING: _____ B. WING _____	04/01/2019

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ABOVE AND BEYOND FAMILY CARE II	316 DENNY CIRCLE GRAHAM, NC 27253

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C 202	Continued From page 16 Interview with Resident #2 on 03/29/19 at 8:05 am revealed she knew she did not remember whether or not she had a TB skin test. Attempted telephone interview with Resident #2's responsible party on 04/01/19 at 12:59 pm was unsuccessful. Interview with a Supervisor-in Charge (SIC) on 04/01/19 at 10:32 am revealed: -The Administrator was responsible for making sure residents had a second TB skin test, but she checked behind her to make sure TB skin tests had been completed. -She did not know if Resident #2's TB skin tests had been completed. -TB skin tests results were kept in the residents' records and she only saw one for Resident #2. -She did not know what happened to Resident #2's second TB skin test. Interview with the Administrator on 03/29/19 at 11:08 am revealed: -She was responsible for ensuring residents had TB skin tests completed. -She thought Resident #2 had two TB skin tests completed upon admission to the facility. -The two TB skin tests should have been in Resident #2's record.	C 202		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .0901 Personal Care And Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001139	A. BUILDING: _____ B. WING _____	04/01/2019

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C 243	Continued From page 17 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 of 1 resident (Resident #1) who exhibited exit-seeking behaviors and eloped from the facility without staff's knowledge. The findings are: Review of Resident #1's current FL2 dated 08/10/18 revealed: -Diagnoses included bipolar, essential hypertension, neuropathy, gastroesophageal reflux disease, and normocytic anemia. -There was documentation Resident #1 was intermittently disoriented. Review of Resident #1's care plan dated 08/10/18 revealed: -Resident #1 had a history of mental illness and was currently prescribed psychotropic medications. -Resident #1 was sometimes disoriented. -Resident #1 required limited assistance with transfers and ambulation and supervision with eating and toileting. -Resident #1 needed a rollating walker for ambulation. Review of Resident #1's Licensed Health Professional Support (LHPS) review dated 02/24/19 revealed: -Resident #1 used a rollating walker for transfers and ambulation. -Resident #1 required assistance with transfers and ambulation at times.	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 243	Continued From page 18 Review of Resident #1's resident care notes revealed: -On 01/26/19, Resident #1 tried to leave the facility to go to the neighbor's house stating she wanted to use the phone. Staff had to get her back in the facility. -On 03/26/19 at 5:30 am, Resident #1 walked out the door and staff had to redirect her into going back into the facility. -On 03/26/19 at 6:30 am, Resident #1 tried to walk out of the facility again. Staff had to stand in front of the door for about an hour while the resident was verbally abusive to staff. -On 03/28/19 at 6:00 am, Resident #1 walked away (one block) from the facility. Staff had to stop and run after her. -Staff got her back in the facility on 03/28/19 and "she tried it again," (tried to elope a second time), but did not get out again. Review of Resident #1's Incident/Accident Reports revealed there was no report documenting an elopement that occurred on 03/28/19. Interview with Resident #1 on 03/28/19 at 10:04 am revealed: -She left the facility this morning, 3/28/19, but did not remember what time it was. -She went up the street to see if she could get some help with a shower. -She did not know whose house she was going to, but she was going to get some help. -The housekeeper and the Supervisor-in-Charge (SIC) brought her back to the facility. Interview with the SIC on 03/28/19 at 10:31 am revealed: -Resident #1 left the facility between 6:30 am and 7:00 am without her knowledge.	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001139	A. BUILDING: _____ B. WING _____	04/01/2019

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ABOVE AND BEYOND FAMILY CARE II	316 DENNY CIRCLE GRAHAM, NC 27253

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C 243	Continued From page 19 -She was assisting another resident with a shower when Resident #1 left the facility. -Resident #1's room was located beside the main entrance door. -There was a lock and an alarm on the main entrance door. -She had heard the door alarm go off, but she thought it was the housekeeper coming in as he did every morning to clean up. -She did not check to see if someone was coming in or leaving out of the facility when she heard the door alarm. -She was alerted Resident #1 had left the facility when the housekeeper ran into the facility yelling Resident #1 was up the street. -About fifteen had passed between the time she heard the door alarm and when she left the facility to go get Resident #1. -She found Resident #1 about a block from the facility on the side of the street in front of a neighbor's house pushing her wheelchair which she had filled with clothes, her purse, personal care items, and two pairs of shoes. -Staff could not keep her from going out of the main entrance door. -There was a lock on the main entrance door, but it always opened from inside the facility when the handle was turned whether the lock was on or not. -The lock on the main entrance door had to be reset every time the door was opened to ensure it locked from the outside. -The police were called by someone in the community and arrived at the facility after the SIC and the housekeeper returned with Resident #1. -Resident #1 tried leaving the facility on 03/26/19 and also this past summer, but she did not remember when. -She did not know of any interventions that were put in place to prevent Resident #1 from eloping	C 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 243	Continued From page 20	C 243		

other than having her to come to the common area more often.
-She had not been told how often she needed to check on Resident #1 when she was in her bedroom.

Interview with Resident #1's guardian on 03/28/19 at 11:53 am revealed:
-She did not know about Resident #1 eloping from the facility on 03/28/19.
-No one from the facility had contacted her regarding the elopement on 03/28/19.
-Resident #1 required assistance with all of her activities of daily living.
-Resident #1 could not be out of her wheelchair for a long time, but could ambulate using her walker and her wheelchair.
-Resident #1 ambulated primarily by propelling herself in the wheelchair.

Telephone interview with the Administrator on 03/28/19 at 2:36 pm revealed:
-She knew about Resident #1 eloping from the facility on 03/28/19.
-The resident had left the facility about ten times going down the steps or in the yard, but this was the first time today, 03/28/19 she had made it out of the yard.
-There were no specific interventions or specific plans to increase supervision put in place after each attempt to elope.
-"We just try to talk her back in."
-"We can't lock them in. That's against the rules."
-Anytime staff heard the alarm, they were supposed to see what was happening.
-When Resident #1 was admitted to the facility, the bedroom by the main entrance was the room that was available.
-She had not thought about moving her to a different bedroom.

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C 243	Continued From page 21 The facility failed to provide supervision for Resident #1 who had physical and mental impairments, exhibited exit-seeking behaviors and eloped from the facility. The facility's failure to provide supervision and implement interventions to address exit-seeking behaviors placed the residents at substantial risk for physical harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 03/29/19 for this violation. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MAY 2, 2019.	C 243		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to assure Resident #1 was free of physical abuse related to alleged physical abuse by the Administrator hitting the resident in the mouth. The findings are: Review of Resident #1's current FL2 dated	C 311		

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C 311	Continued From page 22 08/10/18 revealed: -Diagnoses included bipolar, essential hypertension, neuropathy, normocytic anemia and gastroesophageal reflux disease. -Resident #1's orientation status was intermittent. Review of a local police department Incident/Investigation Report revealed: -An officer was dispatched to the facility on 03/24/19 at 9:21 pm to check on a resident who was possibly assaulted by staff. -The Administrator and another staff were present at the facility when officers arrived. -Resident #1 told the officer the Administrator spit in her face earlier in the day on 03/24/19. -The staff present at the facility with the Administrator reported Resident #1 was still upset about the Administrator accidentally spitting on her earlier and hit the Administrator. -The staff reported the Administrator punched Resident #1 in the mouth and "busted her lip", after the Administrator was hit by Resident #1. -The Administrator reported Resident #1 scratched her on the chest, but she did not hit Resident #1. -The Administrator was arrested by the local police department and charged with felony abuse of an elder person by physical assault. Review of pictures provided by the local police department revealed: -Resident #1 had a small cut on the left corner of her mouth. -The Administrator had scratches on the left side of her chest. -There was no apparent bruising or bleeding from Resident #1 or the Administrator. Review of Resident #1's resident care notes revealed there was no documentation of the	C 311		

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C 311	Continued From page 23 incident that occurred on 03/24/19. Review of Resident #1's Incident/Accident Reports revealed there was no report documenting the incident that occurred on 03/24/19. Review of the Health Care Personnel Registry on 03/28/19 revealed there was no report of the Administrator being involved in an incident with a resident at the facility on 03/24/19. Interview with Resident #1 on 03/28/19 at 10:04 am revealed: -"Did you hear about what happened on Sunday?" -The Administrator was telling everyone what her mental health diagnoses were. -The Administrator hit her seven times in the mouth with her fist and her mouth was bleeding. -She was also hit in the chest. -She was seated in her wheelchair in her room when the Administrator hit her. -She did not know why the Administrator hit her. -She tore the Administrator's shirt and the Administrator pulled out her breast and told Resident #1 to suck them. -The Administrator spit on her three times on the morning of 03/24/19. -The Administrator told Resident #1 she had "cum" on her mouth. -Another staff also hit her in the mouth this year, but she could not remember when. -She did not go to the hospital either time she was hit by staff including the night of 03/24/19. -She did let her guardian know that she was being hit by staff. Interview with a Supervisor-in-Charge (SIC) on 03/28/19 at 10:31 am revealed:	C 311		

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C 311	Continued From page 24 -The Administrator and another staff were at the facility on 03/24/19. -She was called to the facility to work on the evening of 03/24/19. -When she got to the facility, the other staff left and the police took the Administrator with them. -From what she understood, Resident #1 had jumped on the Administrator. -She did not notice any cuts, bruises or bleeding on Resident #1's mouth or face. -She did not see the Administrator on the evening of 03/24/19. -This was the third time Resident #1 hit the Administrator. -She saw Resident #1 grab the Administrator by her neck before, but she had never seen the Administrator touch Resident #1. -She had never seen the Administrator touch any of the residents in a harmful way. Interview with Resident #1's guardian on 03/28/19 at 11:53 am revealed: -She received a text from the Administrator on 03/29/19 at 4:09 am informing her "some stuff went down with [Resident #1] and she had to get out." -Resident #1 had been her client for the last three years. -She talked to the Administrator on the morning of 03/29/19 and the Administrator told her Resident #1 accused her (the Administrator) of hitting her in the mouth. Telephone interview with the Administrator on 03/28/19 at 2:36 pm revealed: -Resident #1 had her nightgown on when she went to administer medication to her around 8:00 pm. -Resident #1 had put a shirt on top of the gown and sweat pants under the gown.	C 311		

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C 311	Continued From page 25 -Resident #1 was upset about the Administrator accidentally spitting on her when talking to her earlier in the day and stated she was going to walk to the hospital to get a tetanus shot. -She asked Resident #1 to wait to go to the hospital and began helping her take her shirt off. -As she was taking Resident #1's shirt off over her head, Resident #1 began fighting, scratching her and tore her shirt all the way off. -Resident #1 was seated in her wheelchair in her room. -She yelled for the other staff to get Resident #1 off of her. -"I had a time getting away from her." -She did not hit Resident #1, but did pry her fingers back so she would let loose of her shirt. -"She told people I smacked her in the mouth, but she didn't have any bleeding. If her mouth was bleeding, it was because she was churning it" (grinding her gums in a circular motion). -"It seems like she takes everything out on me." -The other staff working witnessed the incident on 03/24/19 and there were no other residents present. Attempted telephone interview with the staff present during the incident on 03/28/19 at 3:15 pm and 3:47 pm was unsuccessful. Attempted telephone interview with Resident #1's mental health provider on 04/01/19 at 11:07 am was unsuccessful. _____ The facility neglected to protect Resident #1 from being physically assaulted by the Administrator which resulted in a cut on the corner of Resident #1's mouth. The failure of the Administrator to protect the residents and assure the rights of residents were maintained resulted in serious physical harm and neglect and constitutes a Type	C 311		

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C 311	Continued From page 26 A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/28/19 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 2, 2019.	C 311		
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 assure Medication Administration Records (MARs) were accurate for	C 342		

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C 342	Continued From page 27 2 of 3 sampled residents (Resident #2 and #3). The findings are: 1. Review of Resident #2's current FL2 dated 07/02/18 revealed: -Diagnoses included acute encephalopathy, hypoxia, syncope, dementia with behavior disturbance, chronic obstructive pulmonary disease, and diabetes. -There was an order for Carvedilol 12.5 mg (a beta blocker used to treat high blood pressure and heart failure) one tablet twice daily. Review of Resident #2's Medication Administration Record (MAR) for January 2019 revealed: -There was no entry for Carvedilol 12.5 mg one tablet twice daily. -There was an entry for Carvedilol 6.25 mg one tablet twice daily at 8:00 am and 8:00 pm. -There was documentation Carvedilol 6.25 mg was administered at 8:00 am and 8:00 pm from 01/01/19 through 01/31/19. Review of Resident #2's MAR for February 2019 revealed: -There was no entry for Carvedilol 12.5 mg one tablet twice daily. -There was an entry for Carvedilol 6.25 mg one tablet twice daily at 8:00 am and 8:00 pm. -There was documentation Carvedilol 6.25 mg was administered at 8:00 am and 8:00 pm from 02/01/19 through 02/28/19. Review of Resident #2's MAR for March 2019 revealed: -There was no entry for Carvedilol 12.5 mg one tablet twice daily. -There was an entry for Carvedilol 6.25 mg one	C 342		

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	FCL001139	A. BUILDING: _____ B. WING _____	04/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE AND BEYOND FAMILY CARE II	316 DENNY CIRCLE GRAHAM, NC 27253

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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tablet twice daily at 8:00 am and 8:00 pm.
-There was documentation Carvedilol 6.25 mg was administered at 8:00 am and 8:00 pm from 03/01/19 through 03/28/19 and on 03/29/19 at 8:00 am.

Observation of Resident #2's medications on hand on 04/01/19 at 9:47 am revealed:
-Carvedilol 12.5 mg was available for administration with instructions to administer one tablet twice daily.
-There were sixty tablets dispensed by the pharmacy on 03/29/19.

Interview with a Supervisor-in-Charge (SIC) on 03/29/19 at 6:44 pm revealed:
-The Administrator and SICs were responsible for reviewing new orders, entering new orders on the MAR and sending the new order to the pharmacy.
-New orders received during a shift should have been communicated to the next shift.
-The Administrator completed MAR audits once a month.
-She looked at the MAR when she administered medication to Resident #2, but she had not noticed the order on the MAR for Carvedilol did not match the order on the medication bubble pack.
-She did not remember when the order for Carvedilol 6.25 mg changed to Carvedilol 12.5 mg.
-Carvedilol 12.5 mg should be on the MAR and the pharmacy was responsible for entering it on the MAR once the order was sent.
-The pharmacy had to have the order because the medication bubble pack was labeled Carvedilol 12.5 mg.

Interview with a second SIC on 04/01/19 at 11:29 revealed:

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C 342	Continued From page 29 -The SIC on duty was responsible for reviewing new orders when they came in and making sure new orders were sent to the pharmacy. -The Administrator was responsible for making sure the MARs matched the orders, but did not know how often the Administrator compared the MARs to the orders. -She had administered Carvedilol to Resident #3, but she did not know the MAR did not match the medication label. Telephone interview with a representative from the contracted pharmacy on 04/01/19 at 11:58 am revealed: -There was an original order for Carvedilol 12.5 mg one tablet twice daily dated 04/27/17. -There was a subsequent order for Carvedilol 6.25 mg one tablet twice daily dated 02/26/18. -Carvedilol 6.25 mg was changed to Carvedilol 12.5 mg on 07/02/18. -There had not been any additional changes in the order for Carvedilol. -Carvedilol 12.5 mg was dispensed to the facility on 01/24/19, 02/27/19, and 03/29/19. -The pharmacy was responsible for transcribing orders on the MAR. -If an order was received by the facility after pharmacy hours, the facility staff would be responsible for entering the order on the MAR, then sent the order in to the pharmacy to be transcribed on the MAR for the following month. -The facility should have contacted the pharmacy for any issues with the MAR. -"It wasn't caught by us or by the facility." -He did not know for sure why the order for Carvedilol 12.5 mg was not updated on the MAR. -The pharmacy would correct the order for Carvedilol on the MAR. Telephone interview with the Administrator on	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 342	Continued From page 30 04/01/19 at 1:10 pm revealed: -She was responsible for reviewing MARs when they came to the facility from the pharmacy each month. -A couple of times during the month, she looked at the MARs to make sure they matched the medication dispensed by the pharmacy. -There had been times when the order on the MAR did not match the medication label dispensed by the pharmacy and she contacted the pharmacy to correct it. -She did not know about the current order for Carvedilol 12.5 mg not matching the entry on the MAR. -"I didn't pay any attention." -She would contact the pharmacy to ensure the order for Carvedilol was updated on the MAR. 2. Review of Resident #3's current FL2 dated 01/20/19 revealed: -Diagnoses included dementia, osteoporosis, anxiety, muscle weakness, and difficulty walking. -There was an order for Cranberry Fruit 405 mg (used to prevent urinary tract infections) one capsule twice daily. Review of a physician's order dated 12/12/18 revealed an order to discontinue Cranberry Fruit 405 mg and start Cranberry supplement 450 mg one capsule daily. Review of Resident #3's Medication Administration Record (MAR) for January 2019 revealed: -There was no entry for Cranberry supplement 450 mg one capsule daily -There was an entry for Cranberry Fruit 405 mg one capsule daily at 8:00 am. -There was documentation Cranberry Fruit 405 mg was administered at 8:00 am from 01/01/19	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 342	Continued From page 31 through 01/31/19. Review of Resident #3's MAR for February 2019 revealed: -There was no entry for Cranberry supplement 450 mg one capsule daily -There was an entry for Cranberry Fruit 405 mg one capsule daily at 8:00 am. -There was documentation Cranberry Fruit 405 mg was administered at 8:00 am from 02/01/19 through 02/28/19. Review of Resident #3's MAR for March 2019 revealed: -There was no entry for Cranberry supplement 450 mg one capsule daily. -There was an entry for Cranberry Fruit 405 mg one tablet twice daily at 8:00 am and 8:00 pm. -There was documentation Cranberry Fruit 405 mg was administered at 8:00 am from 03/01/19 through 03/29/19. Observation of Resident #3's medications on hand on 04/01/19 at 9:47 am revealed: -Cranberry 450 mg was available for administration with instructions to administer one capsule daily. -There were thirty capsules dispensed by the pharmacy on 03/11/19. Interview with a Supervisor-in-Charge (SIC) on 03/29/19 at 6:44 pm revealed: -The Administrator and SICs were responsible for reviewing new orders, entering new orders on the MAR and sending the new order to the pharmacy. -New orders received during a shift should have been communicated to the next shift. -The Administrator completed MAR audits once a month.	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 342	Continued From page 32 Interview with a second SIC on 04/01/19 at 10:32 am revealed: -She knew about the change in the order dated 12/12/18 for Cranberry for Resident #3, but she did not realize the MAR did not match the order or the medication label. -She remembered entering the order for Cranberry supplement 450 mg on the MAR and sending the order to the pharmacy, but she did not know why the pharmacy did not update the order on the MAR. Interview with another SIC on 04/01/19 at 11:29 revealed: -The SIC on duty was responsible for reviewing new orders when they came in and making sure new orders were sent to the pharmacy. -The Administrator was responsible for making sure the MARs matched the orders, but did not know how often the Administrator compared the MARs to the orders. -She had administered Cranberry to Resident #3, but she did not know the MAR did not match the medication order. Telephone interview with a representative from the contracted pharmacy on 04/01/19 at 11:58 am revealed: -There was an order dated 12/12/18 to discontinue Cranberry Fruit 405 mg and start Cranberry supplement 450 mg one capsule daily. -Cranberry supplement 450 mg one capsule daily was dispensed to the facility on 01/10/19, 02/11/19, and 03/11/19. -The pharmacy was responsible for transcribing orders on the MAR. -If an order was received by the facility after pharmacy hours, the facility staff was responsible for entering the order on the MAR, then sent the order in to the pharmacy to be transcribed on the	C 342		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 342	Continued From page 33 MAR for the following month. -The facility should have contacted the pharmacy for any issues with the MAR. -"It wasn't caught by us or by the facility." -He did not know for sure why the order for Cranberry 450 mg was not updated on the MAR. -The pharmacy would correct the order for Cranberry on the MAR. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. Telephone interview with the Administrator on 04/01/19 at 1:10 pm revealed: -She was responsible for reviewing MARs when they came to the facility from the pharmacy each month. -A couple times during the month, she looked at the MARs to make sure they matched the medication in the dispensed by the pharmacy. -There had been times when the order on the MAR did not match the medication label dispensed by the pharmacy and she contacted the pharmacy to correct it. -She knew the order for Cranberry had changed to 450 mg daily, but she did not know the order was not changed on the MAR. -She would contact the pharmacy to ensure the order for Cranberry was updated on the MAR.	C 342		
C 428	10A NCAC 13G .1206 Health Care Personnel Registry 10A NCAC 13G .1206 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and	C 428		

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C 428	Continued From page 34 .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to report allegations of physical assault of a resident (#1) by a staff (the Administrator) to the Health Care Personnel Registry (HCPR) within 24 hours and provide documentation the alleged act was investigated and reported to HCPR within 5 days. The findings are: Review of Resident #1's current FL2 dated 08/10/18 revealed: -Diagnoses included bipolar, essential hypertension, neuropathy, normocytic anemia and gastroesophageal reflux disease. -Resident #1's orientation status was intermittent. Review of an Incident/Investigation Report provided by the local police department revealed: -An officer was dispatched to the facility on 03/24/19 at 9:21 pm to check on a resident who was possibly assaulted by an employee. -The Administrator and another staff were present at the facility when officers arrived. -Resident #1 told the officer the Administrator spit in her face earlier in the day on 03/24/19. -The staff present at the facility with the Administrator reported Resident #1 was still upset about the Administrator accidentally spitting on her earlier and hit the Administrator. -The staff reported the Administrator punched Resident #1 in the mouth and "busted her lip"	C 428		

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after the Administrator was hit by Resident #1.
-The Administrator reported Resident #1 scratched her on the chest, but she did not hit Resident #1.
-The case was closed and cleared by the arrest of the Administrator who was charged with felony abuse of an elder person by physicial assault.

Review of the Health Care Personnel Registry website on 03/28/19 revealed there was no report of the Administrator being involved in an incident with a resident at the facility on 03/24/19.

Interview with a Supervisor-in-Charge (SIC) on 03/28/19 at 10:31 am revealed:
-The Administrator and another staff were at the facility on 03/24/19.
-She was called to the facility to work on the evening of 03/24/19.
-When she got to the facility, the other staff left and the police took the Administrator with them.
-She had not completed an incident report or reported the allegation to the healthcare personnel registry because she did not know she needed to.

Telephone interview with the Administrator on 03/29/19 at 12:24 pm revealed:
-She had not completed a report to HCPR regarding Resident #1's allegation of abuse within twenty four hours of the allegation.
-She did notify HCPR on 03/28/19.
-She did not report the allegations to the HCPR within twenty four hours because she did not know she had to.
-If there was an allegation of a staff member abusing a resident, she would talk to both parties individually and then together.
-She would get rid of staff if allegations were found to be true.

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C 428	Continued From page 36 -She would know if allegations were true by knowing the resident, knowing the staff person and observing how the resident reacted to the staff person. -She would document the allegations and place in the staff's file. -She would not notify HCPR or the county if she felt like the allegation did not happen. -She had not had an internal investigation of the allegations of abuse completed. -She would get an Administrator from another facility to complete the investigation. -She had worked at the facility daily, but had not been in the facility since 03/24/19 as advised by county staff. Interview with the Administrator on 04/01/19 at 1:10 pm revealed: -She had not completed an incident report because she was not allowed back in the facility. -She did not have anyone complete an incident report for her. -She notified a county employee on 03/25/19 of the incident that took place on 03/24/19. -She spoke with Resident #1's guardian on 03/25/19 regarding the incident. The facility failed to report allegations of physical abuse to HCPR within 24 hours and complete an investigation and report within five days of becoming aware of allegations the Administrator had a physical altercation with Resident #1 which resulted in a cut on the corner of Resident #1's mouth and the Administrator being arrested and charged with felony abuse of an elder person by physical assault. The facility's failure placed residents at substantial risk for additional physical harm and neglect and constitutes a Type A2 Violation.	C 428		

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C 428	Continued From page 37 The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/01/19 for this violation. CORRECTION-DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 2, 2019.	C 428		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free from physical abuse and neglect regarding Design and Construction, Testing for Tuberculosis, Other Staff Qualifications, Management and Other Staff, Personal Care and Supervision, Health Care Personnel Registry and Residents' Rights. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure the building was equipped and maintained for 1 of 3 sampled residents (#3) residing in the facility who had physical and cognitive impairments and was unable to evacuate independently. [Refer to Tag 0022 10A NCAC 13G .0302(b) Design and Construction (Type B Violation)]. 2. Based on record reviews and interviews, the facility failed to assure 2 of 5 sampled staff (Staff D and Staff E) were tested for tuberculosis (TB) disease upon hire. [Refer to Tag 0140 10A NCAC	C 914		

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C 914	Continued From page 38 13G .0405(a)(b) Testing for Tuberculosis (Type B Violation]. 3. Based on observations, record reviews, and interviews, the facility failed to assure 1 of 5 sampled staff (Staff E) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. [Refer to Tag 0145 10A NCAC 13G .0406(a)(5) Other Staff Qualifications (Type B Violation)]. 4. Based on interviews and record reviews, the facility failed to complete a criminal background check on 1 of 5 sampled staff (Staff E) upon hire. [Refer to Tag 0147 10A NCAC 13G .0406(a)(7) Other Staff Qualifications (Type B Violation)]. 5. Based on observations, interviews, and record reviews, the facility failed to assure that at no time was a resident left alone in the home without a staff member present for 3 of 4 residents (Residents #2 #3 and #4) who had diagnoses including dementia. [Refer to Tag 0187 10A NCAC 13G .0601(b)(2) Management and Other Staff (Type B Violation)]. 6. Based on observations, record reviews, and interviews, the facility failed to provide supervision for 1 of 1 resident (Resident #1) who exhibited exit-seeking behaviors and eloped from the facility without staff's knowledge. [Refer to Tag 0243 10A NCAC 13G .0901(b) Personal Care and Supervision (Type A2 Violation)]. 7. Based on record reviews and interviews, the facility failed to assure Resident #1 was free of physical abuse related to alleged physical abuse by the Administrator hitting the resident in the mouth. [Refer to Tag 0311 10A NCAC 13G .0909 Resident Rights (Type A1 Violation)].	C 914		

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C 914	Continued From page 39 8. Based on record reviews and interviews, the facility failed to report allegations of physical assault of a resident (#1) by a staff (the Administrator) to the Health Care Personnel Registry (HCPR) within 24 hours and provide documentation the alleged act was investigated and reported to HCPR within 5 days. [Refer to Tag 0428 10A NCAC 13G .1206 Health Care Personnel Registry (Type A2 Violation)].	C 914		
C992	G.S. § 131D-45 G.S. § 131D-45. Examination and screening for G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the	C992		

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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
C992	Continued From page 40 physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure 1 of 5 staff sampled (Staff E) had completed an examination and screening for the presence of controlled substances upon hire. The findings are: Review of staff personnel records revealed there was not a personnel record available for Staff E. Attempted telephone interview with Staff E on 03/29/19 at 12:03 pm was unsuccessful. Telephone interview with the Administrator on 03/29/19 at 12:24 pm revealed: -She was responsible for maintaining personnel records and ensuring staff completed a controlled substance examination and screening upon hire. -Staff E had been working at the facility for about a year and was hired to clean up and wash residents' clothes. -She did not complete a controlled substance examination and screening for Staff E because he "just cleaned up." -"We all have people who clean up." -This was the first time she had heard of a	C992		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001139	A. BUILDING: _____ B. WING _____	04/01/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABOVE AND BEYOND FAMILY CARE II	316 DENNY CIRCLE GRAHAM, NC 27253

(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
C992	Continued From page 41 housekeeper needed a controlled substance examination and screening.	C992		