

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Caswell County Department of Social Services conducted an annual survey on 06/05/24.	C 000		
C 069	10A NCAC 13G .0312(g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 3 exit doors that were accessible to two residents (#1, #2) , who were intermittently disoriented, had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents, resulting in one of the residents wandering away from the facility (#1). The findings are: Observation of the area on 06/05/24 at 7:45am: -There was a mental health facility on the main	C 069		

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 069	<p>Continued From page 1</p> <p>highway.</p> <p>-Immediately beside the entrance driveway to the mental health facility, was the entrance driveway for the facility and another facility.</p> <p>-There was a long-graveled road to the two sister facilities that were situated side by side at the end of the driveway.</p> <p>Observation of three entrance/exit doors of the facility on 06/05/24 at various times between 7:45am-6:00pm revealed no alarm sounded when the door was opened and closed.</p> <p>Interview with a resident on 06/05/24 at 4:15pm revealed:</p> <p>-He was allowed to go and come as he pleased, and he could move about on the premises freely.</p> <p>-Since he had been there, there had not been any alarms on the doors.</p> <p>1. Review of Resident #1's current FL-2 dated 07/14/23 revealed:</p> <p>-Diagnoses included schizophrenia and hypertension.</p> <p>-The resident was intermittently disoriented.</p> <p>Review of Resident #1's assessment and care plan dated 01/19/24 revealed:</p> <p>-The resident needed supervision with eating and toileting.</p> <p>-The resident needed limited assistance with ambulation, bathing, dressing, grooming, and personal hygiene.</p> <p>Review of Resident #1's after-visit summary dated 06/04/24 revealed Resident #1's medications were being changed due to behavior changes and the resident had wandered away from the facility.</p>	C 069		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 069	<p>Continued From page 2</p> <p>Interview with the Supervisor-in-Charge (SIC) on 06/05/34 at 3:32pm revealed:</p> <ul style="list-style-type: none"> -About 3-4 weeks ago, at about 11:30pm, Resident #1 was not in his room. -She looked everywhere inside the facility and did not see Resident #1. -She looked around the porch area and did not see Resident #1. -She called the [named] facility (the mental health facility) and asked the staff to look outside their facility for the resident. -The mental health facility staff saw Resident #1 in the yard. -She met the resident halfway and they walked back to the facility together. -The resident told her he went to get a "soda." -The resident then started talking about himself as if he were someone else; he did not do this often. -Resident #1 had never walked away from the facility before. <p>Interview with the Administrator on 06/05/24 at 4:42pm revealed:</p> <ul style="list-style-type: none"> -She talked with the facility's contracted primary care provider (PCP), yesterday, 06/04/24, about the change in Resident #1's behavior, and the PCP was making medication changes. -When Resident #1 walked off about three weeks ago, it was the only time the resident had walked off. -She thought Resident #1 was attention-seeking. <p>Telephone interview with the facility's contracted PCP on 06/05/24 at 3:16pm revealed:</p> <ul style="list-style-type: none"> -She was notified Resident #1 had walked away from the facility and was located at another facility. -The staff at the other facility called about the resident and the staff went and got Resident #1. 	C 069		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 069	<p>Continued From page 3</p> <p>-Resident #1 would need to be supervised when exiting the facility.</p> <p>Based on observations, record reviews, and interviews it was determined Resident #1 was not interviewable.</p> <p>Refer to the interview with the SIC on 06/05/24 at 3:32pm and 5:36pm.</p> <p>Refer to the interview with the Administrator on 06/05/24 at 4:42pm.</p> <p>Refer to the telephone interview with the facility's PCP on 06/05/24 at 3:16pm.</p> <p>2. Review of Resident #2's current FL-2 dated 03/28/24 revealed: -Diagnoses included schizophrenia. -The resident was intermittently disoriented.</p> <p>Review of Resident #2's assessment and care plan dated 01/09/24 revealed: -The resident needed supervision with eating and toileting. -The resident needed limited assistance with ambulation, bathing, dressing, grooming, and personal hygiene.</p> <p>Interview with the SIC on 06/05/24 at 3:32pm revealed: -Resident #2 had very short-term memory. -Resident #2 did not remember, for example, the resident would eat and then forget he had just eaten. -Resident #2 walked around the grounds at the facility and went to the sister facility next door. -Resident #2 had never wandered away from the facility.</p>	C 069		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 069	<p>Continued From page 4</p> <p>Interview with the Administrator on 06/05/24 at 4:42pm revealed:</p> <ul style="list-style-type: none"> -Resident #2 was new so she did not know much about him. -She thought Resident #2 had short-term memory loss because he could not remember names. <p>Telephone interview with the facility's contracted PCP on 06/05/24 at 3:16pm revealed:</p> <ul style="list-style-type: none"> -She documented Resident #2 was intermittently disoriented based on reviewing his record as the resident was new to the facility. -Resident #2 needed to be monitored because if he walked away, he would not know how to find his way back since he was new to the area. <p>Based on observations, record reviews, and interviews it was determined Resident #2 was not interviewable.</p> <p>Refer to the interview with the SIC on 06/05/24 at 3:32pm and 5:36pm.</p> <p>Refer to the interview with the Administrator on 06/05/24 at 4:42pm.</p> <p>Refer to the telephone interview with the facility's PCP on 06/05/24 at 3:16pm.</p> <p>Interview with the SIC on 06/05/24 at 3:32pm and 5:36pm revealed:</p> <ul style="list-style-type: none"> -The residents were supposed to be inside at 10:00pm; the last smoke break was at 8:00pm. -If she had not seen a resident in ten minutes, she would look for the resident. -She did not sleep a lot, she tried to stay awake, but if she did doze off, she would know if a resident opened the door. -There had not been any sounding devices on the exit doors as long as she could remember. 	C 069		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 069	<p>Continued From page 5</p> <p>-There had once been a sounding device on the kitchen door because of residents trying to go into the kitchen.</p> <p>Interview with the Administrator on 06/05/24 at 4:42pm revealed:</p> <p>-The doors observed were new, and the installation was not complete.</p> <p>-A resident broke two of the three exit doors on Saturday, 06/01/24, and the replacement started on 06/04/24.</p> <p>-The exit doors always had chimes on them before being replaced.</p> <p>-She did not think the exit door in the living room had a chime.</p> <p>-She did not know why a chime was not installed on the exit door in the living room.</p> <p>Telephone interview with the facility's contracted PCP on 06/05/24 at 3:16pm revealed:</p> <p>-She was concerned any resident could walk away from the facility.</p> <p>-Even if a resident did not have memory loss, she thought the facility needed door alarms so the staff would know when a resident had left.</p> <p>-Installing alarms would be an intervention to prevent a resident from wandering away from the facility.</p> <p>The failure of the facility to ensure the alarms on the exit doors to the facility had an audible sounding device when activated which resulted in 2 residents (#1,#2) who were intermittently disoriented, having access to the doors allowing Resident #1 to leave the facility without staff knowing he was gone. This failure was detrimental to the safety and welfare of the residents and constitutes a a Type B Violation.</p> <p>The facility provided a plan of protection in</p>	C 069		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 069	Continued From page 6 accordance with G.S. 131D-34 on 06/05//24 for this violation CORRECTION DATE FOR THE TYPE B VIOLATION WILL NOT EXCEED JULY 20, 2024.	C 069		
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure all food items stored by the facility were protected from contamination related to expired food, improper storage of food items in the cabinets, freezer, and refrigerator, and lack of cleanliness in the kitchen including appliances, the pantry, utensil drawers, and the interior of the refrigerator. The findings are:	C 257		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 257	<p>Continued From page 7</p> <p>Observation of the kitchen on 06/05/24 between 8:23am-8:40am revealed:</p> <ul style="list-style-type: none"> -There was a build-up of ice in the upright freezer. -There was a large plastic container of cranberry sauce that was dated as opened on 07/01/23 and expired 09/21/22.; the container was ½ full. -There was a gallon of milk with a best-used date of May 22 (there was no year indicated). -There was a second gallon of milk with a best-used-by date of 04/23/24. -There was an opened bag of hot dogs that were not dated, and the bag was not sealed or dated. -There was a large, open package of bacon, it was not sealed or dated. -There was a plastic container labeled by the manufacturer as barbecue pork and vinegar sauce, the contents were not barbecue pork and were covered in a thick dark grey mold. -There was a resealable plastic bag of slaw that was not labeled or dated. -There was a resealable plastic bag of an unidentified food that was not labeled or dated. -There was an opened bag of ham slices that were not labeled or dated, and the bag was not sealed allowing exposure to the contents. -There was an opened bag of cheese slices that were not labeled or dated, and the bag was not sealed allowing exposure to the contents. -The inside of the refrigerator had food crumbs and sticky brown substances. -There was a bag of molded hot dog buns on a shelf. -There was a plastic container labeled from the manufacturer as barbecue pork and vinegar sauce, the contents were labeled as sugar. -Inside the food closet, there were crumbs and powders on all the shelves. -Inside the utensil drawers, there were crumbs and debris. -The handles to multiple utensil drawers and 	C 257		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 257	Continued From page 8 cabinets had a build-up of grime. -On the inside of the oven door and the sides and bottom of the oven, there was a build-up of a sticky black substance. Interview with the Supervisor-in-Charge (SIC) on 06/05/24 at 3:32pm revealed: -Food was supposed to be sealed and dated; anything opened. -Cleaning the kitchen was the responsibility of a [named] staff member. -She had noticed today, 06/05/24, that the kitchen needed to be cleaned. -She did not know there was food in the refrigerator that had not been labeled. Interview with the Administrator on 06/05/24 at 4:42pm revealed: -Staff were responsible for cleaning the kitchen; whoever was working. -She had not been in the kitchen in the past 2-3 weeks, until today, 06/05/24. -Food should be labeled when opened and in an appropriate container. Attempted telephone interview with the [named] staff member on 06/05/24 at 6:01pm was unsuccessful.	C 257		
C 259	10A NCAC 13G .0904(a)(3) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (3) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule,	C 259		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 259	<p>Continued From page 9</p> <p>for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure there was a five-day supply of non-perishable food maintained in the facility based on the menus for the six residents residing at the facility.</p> <p>The findings are:</p> <p>Review of the menu posted in the kitchen on 06/05/24 at 8:25am revealed no menu was posted.</p> <p>Review of the menu book provided by the Supervisor-in-charge (SIC) on 06/05/24 at 8:38am revealed:</p> <ul style="list-style-type: none"> -An example of a daily menu included breakfast, lunch, and dinner. -Breakfast was 6 ounces of orange juice, 1 scrambled egg, 2 strips of bacon, ½ cup of cream wheat, 1 slice of toast with jelly, milk, coffee, and water. -Lunch was 3 ounces of fish, 1 cup of French fries, ½ cup of slaw, 1 serving of hush puppies, ½ cup of lemon pudding, 1 teaspoon of tartar sauce, coffee, tea, and water. 	C 259		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 259	<p>Continued From page 10</p> <ul style="list-style-type: none"> -Dinner was ½ cup of tossed salad, 3 ounces of creamed turkey, ½ cup of buttered noodles, ½ cup of stewed tomatoes, 1 slice of wheat bread, ½ cup of ice cream, milk, and a second beverage. -Bedtime snack was milk and ½ sandwich. <p>Observation of the food closet on 06/05/24 at 8:32am revealed:</p> <ul style="list-style-type: none"> -There were 4 bags of grits: each bag contained 57, 1 cup servings. -There were 3 containers of oatmeal: each container was 30, ½ cup servings. -There were 2 bags of dried split peas; each bag contained 26, 1/4 cup servings. -There was a plastic container that was not labeled, the contents were rice and there were less than 2 cups. -There were two resealable plastic bags of spaghetti noodles. -There was a can of yams; there were 3, 2/3 cups servings. -There was a can of unsweetened applesauce: there were 3.5, ½ cup servings. -There were two boxes of macaroni and cheese; each box contained 3, 1/3 cup servings. -There were two individual serving containers of mixed fruit. -There were multiple bags of marshmallows. <p>Observation of a shelf in the kitchen on 06/05/24 at 8:36am revealed:</p> <ul style="list-style-type: none"> -There was an opened package of grits and oatmeal. -There were multiple bags of bread; one bag of bread was molded. <p>Interview with the Supervisor-in-Charge (SIC) on 06/05/24 at 3:32pm revealed:</p> <ul style="list-style-type: none"> -The Administrator usually came to the facility to 	C 259		

Division of Health Service Regulation
STATE FORM

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 272	<p>Continued From page 12</p> <p>Based on observations, record reviews, and interviews the facility failed to offer snacks to the residents three times a day.</p> <p>Review of the menu book provided by the Supervisor-in-charge (SIC) on 06/05/24 at 8:38am revealed: -Bedtime snack was milk and ½ sandwich -There was no other snack listed.</p> <p>Observation of the kitchen on 06/05/24 between 8:23am-8:40am revealed: -There were two individual serving containers of mixed fruit. -There were multiple bags of marshmallows. -There were no other snack foods identified.</p> <p>Interview with a resident on 06/05/24 at 7:59am revealed: -The residents needed snacks. -The residents were served snacks, "sometimes." -They were served a fruit cup every once in a while, as a snack; he could not remember the last time he was served a fruit cup.</p> <p>Interview with a second resident on 06/05/24 at 8:03am revealed snacks were served, "every now and then."</p> <p>Interview with a third resident on 06/05/24 at 8:07am revealed: -Snacks were served "sometimes." -There were times he got hungry between meals.</p> <p>Interview with a fourth resident on 06/05/24 at 8:10am revealed: -Snacks were not served "often." -He wished snacks were served more often.</p> <p>Interview with the Supervisor-in-Charge (SIC) on</p>	C 272		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 272	Continued From page 13 06/05/24 at 3:32pm revealed: -Snacks were served at 10:00am, 2:00pm, and 7:00pm. -The residents were served fruit cups, chips, popcorn, granola bars, and juices. -When she was working, she brought in things she knew the residents liked such as popcorn. -When she was not working, the Administrator usually made sure there were snacks in the facility. Interview with the Administrator on 06/05/24 at 5:36pm revealed: -Snacks were supposed to be served three times per day on the weekends. -Snacks were served once a day Monday-Friday because the residents went to a day program. -Snacks provided were fruit cups, chips, and rice krispy snacks.	C 272		
C 273	10A NCAC 13G .0904(d)(3) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary Guidelines for Americans 2020-2025, which are hereby incorporated by reference, including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf , at no cost.	C 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 273	<p>Continued From page 14</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents were served one and a half cups of fruit daily and 3 cups of dairy as recommended based on the U.S. Department of Agriculture Dietary Guidelines for Americans.</p> <p>The findings are:</p> <p>Review of the U.S. Department of Agriculture Dietary Guidelines for Americans 2020-2025 revealed:</p> <ul style="list-style-type: none"> -Adults aged 19-59 and 60+ should consume a minimum of 1 1/2 cups of fruit daily for a 1600-calorie diet and up to 2 cups for higher caloric diets. -The fruit food group included whole fruits and 100% fruit juice. -Whole fruits included fresh, canned, frozen, and dried forms. -Whole fruits could be eaten in various forms, such as cut, sliced, diced, or cubed. -At least half of the recommended amount of fruit should come from whole fruit, rather than 100% juice. -When juices were consumed, they should be 100% juice and always pasteurized or 100% juice diluted with water (without added sugars). -Adults age 60+ should consume dairy to equal 3 cups per day. <p>Observation of the refrigerator and the freezer on 06/05/24 at 8:23am revealed:</p> <ul style="list-style-type: none"> -There was a gallon of milk with a best-used date of May 22 (there was no year indicated). -There was a second gallon of milk with a best-used-by date of 04/23/24. 	C 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 273	<p>Continued From page 15</p> <ul style="list-style-type: none"> -There was an opened bag of cheese slices that were not labeled or dated, and the bag was not sealed allowing exposure to the contents. -There were 16 individual cartons of milk; the best-used date was May 2 (there was no year indicated). -There was a can of unsweetened applesauce: there were 3.5, ½ cup servings. -There were two individual serving containers of mixed fruit. -There were no frozen fruits or fruit juices. -There were multiple individual containers of 100% apple juice from concentrate; the juice boxes were not dated with a best-used-by date. <p>Review of the manufacturers guidelines for the individual containers of apple juice revealed juices were delivered frozen. The juice should be thawed under refrigeration and used within 10-days of thawing.</p> <p>Review of the menu book provided by the Supervisor-in-charge (SIC) on 06/05/24 at 8:38am revealed:</p> <ul style="list-style-type: none"> -An example of a daily menu included breakfast, lunch, and dinner. -Breakfast was 6 ounces of orange juice, 1 scrambled egg, 2 strips of bacon, ½ cup of cream wheat, 1 slice of toast with jelly, milk, coffee, and water. -Lunch was 3 ounces of fish, 1 cup of French fries, ½ cup of slaw, 1 serving of hush puppies, ½ cup of lemon pudding, 1 teaspoon of tartar sauce, coffee, tea, and water. -Dinner was ½ cup of tossed salad, 3 ounces of creamed turkey, ½ cup of buttered noodles, ½ cup of stewed tomatoes, 1 slice of wheat bread, ½ cup of ice cream, milk, and a second beverage. -Bedtime snack was milk and ½ sandwich. 	C 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 273	<p>Continued From page 16</p> <p>Observation of the dinner meal service on 06/05/24 at 4:10pm revealed:</p> <ul style="list-style-type: none"> -The residents were served a large piece of fish. -One cup of rice. -One-half cup of broccoli. -One-half cup of zucchini. -Beverages included water and tea. -There was no fruit juice or fruit served. -The milk available to be served was expired. <p>Interview with four residents on 06/05/24 between 7:48am-8:28am revealed:</p> <ul style="list-style-type: none"> -The residents were not served milk daily. -One resident stated milk was served "sometimes." -A second resident stated milk was served "every so often." -He liked milk and would drink milk if it was served. -A third resident stated milk was served "every once in a while: -He thought milk was served last week; he liked milk and would drink more often. -A fourth resident stated he was served milk with cereal. -He would like to have milk to drink at meals. -The residents were not served fruit or fruit juice daily. -One resident stated fruit or fruit juice was served "every once in a while." -A second resident stated he was served juice, sometimes. -He was last served juice last week and had apples "several weeks ago." -A third resident liked juice and did not recall when juice was last served. <p>Interview with the Supervisor-in-Charge (SIC) on 06/05/24 at 3:32pm revealed:</p>	C 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 273	<p>Continued From page 17</p> <ul style="list-style-type: none"> -Milk was served with cereal. -She offered milk to the residents 2-3 times per week during lunch or dinner. -The residents usually wanted Kool-Aid or tea. -The residents were served fruit cups. -The residents had watermelon two days ago. -Fruit delivered to the facility included fruit cocktail, apples, and oranges. -There were apples and oranges served last week. <p>Interview with the Administrator on 06/05/24 at 4:42pm revealed:</p> <ul style="list-style-type: none"> -Fruit juices were delivered frozen because they had a longer shelf life. -She did not know the process of delivery to the facility, as a [named] staff member handled that. -Individual cups of apples, mandarin oranges, pears, and peaches, were delivered to the facility. -She thought there had been fresh apples and oranges at the facility, "maybe last month." -Food was delivered every two weeks. -Staff should be offering milk three times per day. -She did not know the milk in the refrigerator was expired. <p>Attempted telephone interview with the [named] staff person who handled the facility's food on 06/05/24 at 6:02pm was unsuccessful.</p>	C 273		
C 315	<p>10A NCAC 13G .1002(a) Medication Orders</p> <p>10A NCAC 13G .1002 Medication Orders</p> <p>(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:</p> <p>(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours</p>	C 315		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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	<p>Continued From page 18</p> <p>of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to clarify an order for 1 of 3 sampled residents (#2) related to an antipsychotic medication.</p> <p>The findings are:</p> <p>Review of Resident #2's FL-2 dated 03/13/24 revealed: -Diagnosis was schizophrenia. -There was an order for Prolixin (used to treat allergies) 5mg daily.</p> <p>Review of Resident #2's FL-2 dated 03/28/24 revealed no order for Prolixin 5mg to be administered daily.</p> <p>Review of Resident #2's April 2024 medication administration record (MAR) revealed: -There was an entry for Prolixin 5mg to be administered once daily with a scheduled administration time of 8:00am. -There was documentation that Prolixin 5mg was administered daily from 04/01/24-04/30/24.</p> <p>Review of Resident #2's May 2024 MAR revealed: -There was an entry for Prolixin 5mg to be administered once daily with a scheduled administration time of 8:00am.</p>	C 315		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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	<p>Continued From page 19</p> <p>-There was documentation that Prolixin 5mg was administered daily from 05/01/24-05/31/24.</p> <p>Review of Resident #2's June 2024 MAR from 06/01/24-06/05/24 revealed:</p> <p>-There was an entry for Prolixin 5mg to be administered once daily with a scheduled administration time of 8:00am.</p> <p>-There was documentation that Prolixin 5mg was administered daily from 06/01/24-06/05/24.</p> <p>Observation of Resident 1's medications on hand on 06/05/24 at 11:53am revealed Prolixin 5mg was available to be administered.</p> <p>Telephone interview with a representative at the facility's contracted pharmacy on 06/05/24 at 1:21pm revealed:</p> <p>-Resident #2's FL-2 dated 03/13/24 was received at the pharmacy and a 7-day supply was dispensed on 03/27/24.</p> <p>-On 04/01/24, an additional 21 tablets of Prolixin were dispensed, to get the resident's medication on cycle with the facility's other medications.</p> <p>-On 04/30/24 Resident #2's primary care provider (PCP) sent in a prescription for Resident #2's Prolixin 5mg daily.</p> <p>-The pharmacy did not receive Resident #2's FL-2 dated 03/28/24.</p> <p>-When the Prolixin was not on Resident #2's FL-2 dated 03/28/24, the facility staff should have called the PCP to clarify the order for the medication.</p> <p>-The staff at the facility could have also notified the pharmacy and they would have clarified the order.</p> <p>Telephone interview with Resident #2's PCP on 06/05/24 at 3:16pm revealed if Resident #2's Prolixin was missed on the FL-2, she would have</p>	C 315		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 20 expected the facility staff to have made her aware and she could have gotten the order corrected. Interview with the Supervisor-in-Charge (SIC) on 06/05/24 at 3:32pm revealed: -When a new FL-2 was received she or a [named] Administrator reviewed the FL-2 and matched it with the resident's MAR and medications on hand and if it did not match she would notify the Administrator or call the PCP. -She had not noticed Resident #2's Prolixin was not on the current FL-2. Interview with the Administrator on 06/05/24 at 4:42pm revealed when a new FL-2 was completed and signed on a resident, the staff member working should compare the new FL-2 to the MAR and the medications on hand and if there were any discrepancies, the staff member should reach out to the PCP for clarification.	C 315		
C 330	10A NCAC 13G .1004(a) Medication Administration 10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, prescription and non-prescription and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 3 sampled	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	<p>Continued From page 21</p> <p>residents (#1) related to an inhaler.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 07/14/23 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included schizophrenia and hypertension. -The resident was intermittently disoriented. -There was no order for a Breo Ellipta inhaler (used to treat and prevent wheezing and shortness of breath). <p>Review of Resident #1's April 2024 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for Breo Ellipta 200-25mcg, inhale one puff by mouth daily with a scheduled administration time of 8:00am. -There was documentation that the Breo Ellipta was administered at 8:00am daily from 04/01/24-04/30/24. <p>Review of Resident #1's May 2024 MAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for a Breo Ellipta inhaler to be administered once daily with a scheduled administration time of 8:00am. -There was documentation that the Breo Ellipta inhaler was administered daily from 05/01/24-05/31/24. <p>Review of Resident #1's June 2024 MAR from 06/01/24-06/05/24 revealed:</p> <ul style="list-style-type: none"> -There was an entry for a Breo Ellipta inhaler to be administered once daily with a scheduled administration time of 8:00am. -There was documentation that the Breo Ellipta inhaler was administered daily from 06/01/24-06/05/24. 	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	<p>Continued From page 22</p> <p>Observation of Resident 1's medications on hand on 06/05/24 at 11:53am revealed a Breo Ellipta inhaler with the directions to inhale one puff daily was dispensed on 03/11/24; 13 puffs were remaining.</p> <p>Telephone interview with a representative at the facility's contracted pharmacy on 06/05/24 at 1:21pm revealed: -Resident #1's had an order dated 10/06/23, for the Breo Ellipta with the directions to inhale one puff once daily. -Resident #1's Breo Ellipta was dispensed on 02/14/24, 03/11/24, and 04/01/24 for a 30 day supply each dispensing. -Resident #1's Breo Ellipta had not been cycle-filled and the facility staff would have needed to request a refill.</p> <p>Telephone interview with a Pharmacist at the facility's contracted pharmacy on 06/05/24 at 1:47pm revealed: -Resident #1's Breo Ellipta inhaler was used to prevent worsening of chronic lung disease symptoms. -If the inhaler was not administered correctly, the resident may experience a worsening of any symptoms he was experiencing such as shortness of breath or coughing.</p> <p>Telephone interview with Resident #2's PCP on 06/05/24 at 3:16pm revealed: -Resident #1 was ordered the Ellipta inhaler because the resident had asthma. -If Resident #1's Ellipta was not administered as ordered he could experience an asthma attack or worsening of symptoms.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 06/05/24 at 3:32pm revealed:</p>	C 330		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 330	Continued From page 23 -There were no other inhalers available for Resident #1, just the one provided (dated 03/11/24). -Resident #1's inhaler used to be automatically refilled. -Resident #1 had not refused the inhaler, he might refuse at that time, but would return later to get the medication. -She did not know why puffs were remaining in the inhaler. Interview with the Administrator on 06/05/24 at 4:42pm revealed: -When a resident's inhaler was low, the SIC was responsible for calling the pharmacy to reorder. -Resident #1's inhaler should be reordered monthly. -If Resident #1 was refusing the inhaler it should be documented. -She expected the medication to be administered as ordered.	C 330		
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;	C 342		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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	<p>Continued From page 24</p> <p>(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and</p> <p>(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).</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records were accurate for 1 of 3 sampled residents including an antipsychotic medication used to treat schizophrenia (#1).</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 07/14/23 revealed: -Diagnoses included schizophrenia and hypertension. -The resident was intermittently disoriented. -There was an order for Clozapine (an antipsychotic medication used to treat schizophrenia) 100mg take one and a half tablets at bedtime.</p> <p>Review of Resident #1's primary care provider's (PCP) order dated 03/12/24 revealed: -Resident #1 was going to be weaned off his Clozapine by decreasing the dose by 50mg weekly until discontinued with a start date of 03/15/24. -Week one 250mg night for 7 days. -Week two 200mg each night for 7 days. -Week three 150mg each night for 7 days. -Week four 100mg each night for 7 days. -Week five 50mg each night for 7 days; then</p>	C 342		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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	<p>Continued From page 25</p> <p>discontinue the medication.</p> <p>Review of Resident #1's April 2024 medication administration record (MAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for Clozapine 100mg take one tablet at bedtime for 7 days. -There was documentation that Clozapine 100mg was administered from 04/01/24 to 04/30/24 at 8:00pm. -There was no other entry for Clozapine. <p>Telephone interview with a representative at the facility's contracted pharmacy on 06/05/24 at 1:21pm revealed:</p> <ul style="list-style-type: none"> -Resident #1 Clozapine was dispensed once a week for a 7-day supply with the following taper. -On 03/12/24, Clozapine 100mg take 2 ½ tablets for 7 days. -On 03/17/24, Clozapine 100mg take 2 tablets for 7 days. -On 03/22/24, Clozapine 100mg take 1 ½ tablets for 7 days. -On 03/28/24, Clozapine 100mg take 1 tablet for 7 days. -On 04/03/24, Clozapine 25mg take 2 tablets for 7 days. -MARs were sent monthly. -The staff at the facility should have used a blank MAR to write the Clozapine taper in, so it was clear what the resident would receive each week. <p>Based on a review of records and interviews, there would not have been any Clozapine on hand to administer between 04/19/24-04/30/24 and the amount to be administered between 04/12/24-04/18/24, would have been 50mg, not 100mg as documented.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 06/05/24 at 3:32pm revealed:</p>	C 342		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 26 -When new medication was sent from the pharmacy, the pharmacy may or may not send a new MAR. -For medication that was tapered, when the medication was sent each week a new MAR should have been sent with the medication, "the current pharmacy did not do that." -She did not know why she did not write the taper each week. Interview with the Administrator on 06/05/24 at 4:42pm revealed: -She expected the SIC to write in the tapered order for Resident #1's Clozapine and document it on the MAR according to the taper. -She expected staff to document the administration of every medication on the MARs. -If a medication was not listed on the MAR, the SIC could write the medication in on the MAR and notify the pharmacy to have a MAR delivered with the medication listed. -A second Administrator was responsible for auditing the MARs. Interview with the second Administrator on 06/05/24 at 6:02pm revealed: -He audited the MARs at the facility once a month. -He audited the MARs in May 2024. -He had not seen the error in the documentation for Resident #1's Clozapine taper.	C 342		
C 352	10A NCAC 13G .1006 (a) Medication Storage 10a NCAC 13G .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the	C 352		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 352	<p>Continued From page 27</p> <p>facility's medication storage policy and procedures.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications remained under the direct supervision of staff in charge of medication administration at all times including a bottle of Miralax (a stool softener) and multiple tablets of medication found on the floor in a resident's room.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 07/14/23 revealed: -Diagnoses included schizophrenia and hypertension. -The resident was intermittently disoriented. -Medication orders included Metoprolol (used to treat high blood pressure) 100mg, Omeprazole (used to treat reflux) 20mg, Lisinopril (used to treat high blood pressure) 30mg, Haloperidol (an antipsychotic used to treat mental disorders) 5mg, Clozapine (an antipsychotic medication used to treat schizophrenia) 100mg, Trazadone (an antidepressant) 100mg, Simvastatin (used to treat high cholesterol) 10mg, Desmopressin (an antidiuretic used to treat the body losing fluid) 0.1mg and Acetaminophen (used to treat mild pain) 325mg</p>	C 352		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2		STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 352	<p>Continued From page 28</p> <p>Observation of Resident #1's room on 06/05/24 at 2:27pm revealed:</p> <ul style="list-style-type: none"> -There was a bottle of Miralax on top of the resident's dresser. -The bottle of Miralax was not labeled for the resident in the room. -There were 4 whole tablets and multiple broken tablets of medication on the floor in the resident's room. <p>Observation of Resident #1's medication on hand 06/05/24 at 11:36am revealed none of the tablets could be confirmed to resemble the medications found in the resident's room.</p> <p>Interview with the Supervisor-in-Charge (SIC) on 06/05/24 at 3:32pm revealed:</p> <ul style="list-style-type: none"> -She did not know where the tablets found on Resident #1's floor would have come from. -All residents' medications were administered individually in the medication room. -She made sure the residents swallowed the medications before walking away but maybe the resident "cheeked" the medication and then spit it out later. -One of the tablets resembled a controlled substance, Lacosamide (used to treat seizures) that was ordered for another resident. -The other resident had been Resident #1's roommate. -She had not seen a bottle of Miralax in Resident #1's room. -The resident's name on the bottle of Miralax had not been a resident at the facility. -She did not know who the Miralax belonged to or where Resident #1 would have gotten the bottle of Miralax. <p>Interview with the Administrator on 06/05/24 at</p>	C 352		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL017056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 06/05/2024
NAME OF PROVIDER OR SUPPLIER ABUNDANT LIVING # 2			STREET ADDRESS, CITY, STATE, ZIP CODE 3816 CHERRY GROVE ROAD ELON, NC 27244		
(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 352	<p>Continued From page 29</p> <p>4:42pm revealed:</p> <ul style="list-style-type: none"> -There should be no medications in a resident's room. -Medications were to be administered at the medication room. -The SIC should make sure the medication had been swallowed by encouraging the resident to do a "tongue roll" before walking off. -No residents had an order to self-administer medication. -She did not know the resident whose name was on the Miralax bottle or how the medication got to the facility. -The resident may have brought the medication from the day program where they were with other residents. <p>Telephone interview with the facility's contracted Primary Care Provider (PCP) on 06/05/24 at 3:16pm revealed:</p> <ul style="list-style-type: none"> -Residents should not have medication in their rooms. -If a resident were to take the Miralax it could cause the resident to have diarrhea. -None of the residents had an order to self-administer medications. -If tablets were found in a resident's room, it was concerning the resident was not receiving the medication as ordered. -She expected the SIC to watch the residents take their medications before the resident walked away. <p>Based on observations, record reviews, and interviews it was determined Resident #1 was not interviewable.</p>	C 352			