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A VISION COME TRUE	220 HATCH STREET BURLINGTON, NC 27217

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on January 2, 2020 and January 3, 2020 with an exit conference via telephone on January 6, 2020.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to maintain an environment free of hazards as evidenced by bed bugs in 5 of 5 resident rooms . The findings are: Observation of resident room #2 on 01/02/20 at 3:59pm revealed: -There were two beds in the room and each bed was made and had a blanket on top of the sheets; there were white zippered covers on the mattresses and box springs. -There were small black spots and blood stains on the zippered covers; there were dead bed bugs and dark brown debris in the creases of the	D 079		

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D 079	Continued From page 1 sheets. -There were multiple dead bed bugs on the floor around both beds; there was dark brown debris and spots on the floor. Observation of a resident who resided in room #2 on 01/02/20 at 3:59pm revealed he did not have bumps or bites on his wrist, arms or legs. Interview with a resident who resided in room #2 on 01/02/20 at 3:58pm revealed: -He had seen bed bugs in his room, but he had not seen them in a "long while"; he could not remember the last time he saw a bed bug. -The Administrator had "set off bug bombs" during the summer; he had not seen any since then. -He washed his own sheets every two weeks. -He did not have any bites on him, and he had not itched. Observation of resident room #1 on 01/02/20 at 4:15pm revealed: -There were two beds in the room; both beds had white zippered covers on the mattress and box springs. -One of the beds was made and had a pillow, a fitted sheet, a top sheet and a blanket on it and the second bed only had a fitted sheet and a pillow. -There was one small live bed bug and one very large bed bug on the first bed; the resident that resided in the room killed the bugs with his fingers. -There were dark spots and dried blood smeared on the walls beside the first bed. -There was a night stand with multiple spots of dried blood smeared on it. -There was dried blood and dark spots on the headboard of the first bed.	D 079		

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D 079	Continued From page 2 -There were dried spots of blood on the sheet and box spring cover of the second bed; there was loose dark brown debris and multiple dead bed bugs in the creases of the fitted sheet. -There were multiple dead bed bugs and dark brown and black debris on the bed rails. -The footboard of the second bed had a thick layer of white-gray dust and multiple dead bed bugs on the decorative ledges. -There were multiple dark spots and blood smears on the walls around the second bed . -There were multiple dead bed bugs, dark brown spots and black debris on the floor around both beds. Observation of one of the residents who resided in room #1 on 01/02/20 at 4:20 revealed he had no scratch marks or bites on his arms. Interview with a resident who resided in room #1 on 01/02/20 at 4:15pm revealed: -The bed bugs made him itch during the night; just two nights before he woke up itching. -He did not sleep at night due to the itching; he itched too much at night to sleep. - "I sleep and then wake up killing and fighting a bed bug or itching." -He told the Administrator about the bed bugs about a month ago, but his room was not treated. -He washed his sheets and blanket once a week and kept moth balls in his dresser drawer to keep the bed bugs off his clothes. -He tried to keep his room clean and he killed the bed bugs when he saw them. -The Administrator treated his room two or three times when he first saw the bed bugs three or four months ago, maybe longer. Observation of resident room #3 on 01/03/19 at 11:30am revealed:	D 079		

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D 079	Continued From page 3 -There were two beds in the room, each bed was made up with sheets, pillows and blankets; each bed had box spring covers and mattress covers. -There were black and brown spots and dried blood on the box spring covers for both beds. -There were black and brown spots on one of the headboards and numerous dead bed bugs in the decorative edges of the headboard. -There were blood smears and dark spots on the walls around the beds. -There were multiple dead bed bugs and dark brown debris on the floor between one of the beds and the night stand. -There was a dead bed bug and multiple dark brown spots on the door jamb . Observation of resident room #4 on 01/03/20 at 11:52am revealed: -There were two beds in the room; a resident was laying under the covers on one of the beds watching television. -There were white zippered covers with multiple blood stains on the mattress and box springs the resident was laying on. -There were multiple dead bed bugs on the floor between the resident's bed and the nightstand. -There were multiple spots of blood and dark brown debris in the creases of the second bed; there were several large dead bed bugs in one of the corners of the fitted sheets. -There were multiple dead bed bugs and dark brown debris on the floor around the bed. Interview with resident who resided in room #4 on 01/03/20 at 11:49am revealed: -The bed bugs were "not nearly as bad" as they used to be. -He washed his own sheets once a week without supervision. -He washed his sheets on 01/02/20 and he saw	D 079		

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dead bugs on his sheets when he washed them.
-He last saw live bed bugs on his bed a few months ago; he saw the live bugs go into the washer.
-He did not need to tell the Administrator about the live bed bugs because she already knew; the Administrator had sprayed the bed and used a fogger about three months before.
-The Administrator had given him zippered covers for his mattress and box springs.
-He did not know if he was bitten by any bed bugs, but he woke up at 1:00am about three or four nights ago and was itching; he used a regular moisturizing lotion and went back to sleep.

Observation of resident room #5 on 01/03/20 at 11:57am revealed:
-There were two beds in the room and there were white zippered covers on both beds and box springs.
-A resident was sitting on one of the beds; the other bed was unmade.
-There were blood stains and dark spots on the mattress and box spring covers of the unmade bed.
-There was a dark brown debris, multiple dead bed bugs and two large live bed bugs on the sheets of the unmade bed.
-There were blood stains on the wall and the headboard of the unmade bed.
-There was a dark brown debris, dead bed bugs and dried dark spots on the floor surrounding the unmade bed.

Observation of a resident who resided in room #5 on 01/03/20 at 12:09pm revealed there were no visible scratches or bumps on his arms, stomach or ankles.

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Interview with a resident who resided in room #5 on 01/03/20 at 11:58am revealed:
-He and his roommate washed their own sheets every Friday, but he had not washed his sheets in two weeks.
-He washed his sheets by himself; no one watched him because he knew how to wash and dry his own sheets.
-He did not have his own set of sheets; he used sheets from the storeroom and put them on his bed.
-He saw the stains on the sheets; they were blood stains from the bed bugs because "they suck you like a vampire".
-He had not seen live bed bugs for the last month; he had not been bitten and he did not itch.
-The Administrator had sprayed the beds and set off a fogger in the summer; he had not seen bed bugs since then.
-He cleaned his own room; only the Administrator treated his room for the bed bugs.

Interview with the second resident who resided in room #5 on 01/03/20 at 12:04pm revealed:
-He had seen live bed bugs and had been bitten by them, but he did not know when.
-He had let the Administrator know he had seen bugs and had been bitten when it happened; he had learned to "just live with it".
-The Administrator put a "bug killer" in the corner of his room about three or four months ago and had sprayed his room three to four times since then.
-He saw the live bed bugs on his bed on 01/03/20 and he killed them.

Review of the facility's current N.C. Department of Environmental Health sanitation inspection report dated 06/06/2019 revealed:
-Observed mattresses and box springs with

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evidence of bed bugs; encasements had been placed over mattresses and box springs.
-Detailed cleaning was needed of floors especially behind and along floor wall borders.
-Bed bugs were present in several residents' rooms.
-Observed dead bed bugs and one live one [bed bug]; call licensed pest control.

Interview with the Administrator on 01/03/20 at 3:12pm revealed:
-When the resident first told her about the bed bugs she set off "bombs" and foggers in the residents' rooms to kill the bed bugs; that was sometime during the summer in 2019.
-She knew there were still bed bugs in some of the resident's rooms because two to three weeks ago one of the residents told her he found live bed bugs in his bed.
-She personally cleaned the residents' rooms; she started with room #1 and ended with room #6.
-She had started to clean the rooms and spray for the bed bugs again sometime around the middle of November 2019; she sprayed and cleaned the bed frames, legs of the beds, the mattresses and box springs.
-She had placed all the residents' mattresses and box springs inside of covers about a month ago; the covers were supposed to keep the bed bugs out of the mattress and box springs.
-She did not see as many bed bugs, dead or alive, as she did when she first started to clean the rooms.
-She had seen the spots of blood on the residents' sheets when she cleaned their rooms, but she did not see as many as she had before she treated and sprayed the rooms.
-She knew blood spots on the sheets were evidence of a bed bug problem.

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-The residents' sheets and covers were put into the washing machine and then the dryer; only half a basket at a time were placed into the washer and dryer.
-There were only two residents that did not wash their own clothes; the remainder of the residents washed their own clothes and sheets.
-She looked at the amount of clothes the residents put into the washer before they washed their clothes and sheets to make sure they did not "overload" the washer and dryer.
-She knew heat was the key to killing bed bugs and bedbug eggs.
-She read on line about how to treat for bed bugs; she had not sought out professional help in the effort to treat the facility for the bed bugs.
-She thought she could treat and control the bed bug problem herself; she did not want to hire a professional company because she did not feel the facility could afford the expense.
-She had not had a professional company come into the facility to give her an estimate of the cost; from what she guessed it would cost seven to eight thousand dollars to treat the facility.
-She tried to narrow down which residents' rooms still had bed bugs.
-She spent "days and weeks" cleaning and washing everything the residents owned; she started the process about a month ago and had repeated it all over again once she finished.
-She repeated the process over because she knew bed bugs were "hard" to get rid of and lived a long time; she did not know how long it would take to completely get rid of the bed bugs.
-She got it "down to one room" but then they [bed bugs] came back and she had to start all over again because she could not "get them [bed bugs] all".
-She thought the bed bugs had come in when new residents were admitted to the facility; she

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D 079	Continued From page 8 should have inspected new residents' belongings before they came inside the facility. -She did not do anything to prevent bed bugs from being brought back into the facility when residents brought anything new into the facility. -The residents had not come to her with any complaints of scratches or bites. -She had one resident complain about live bugs on his bed about two weeks ago, but he did not have any bite marks. -She had examined residents when she first found out about the bed bugs; a few residents had bumps on their arms and legs and had been seen by their primary care physician (PCP). -The only prevention she did to keep the residents from being bitten by bed bugs was to clean and spray the rooms and to wash the residents' clothes and sheets. Interview with the facility's contracted Nurse Practitioner (NP) on 01/03/20 at 4:07pm revealed: -She was aware the facility had bed bugs and that residents had been complaining about being bitten and itching. -She had not seen evidence of bites or scratch marks on any of the residents when she visited. The failure of the facility to maintain an environment free of hazards by not properly treating and cleaning for bed bugs for seven months resulting in residents being bitten and itching; and live and dead bed bugs in five resident rooms. 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 01/06/20 for this violation.	D 079		

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D 276	Continued From page 9	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, it was determined the facility failed to assure implementation of physician's orders for 1 of 3 sampled resident (#1) with orders for fingerstick blood sugar (FSBS) checks twice daily. The findings are: Review of Resident #1's current FL-2 dated 07/16/19 revealed: -Diagnoses included diabetes, unspecified schizophrenia spectrum, history of alcohol use, history of cocaine use, and intellectual disability. -There was an order for FSBS twice daily. Review of Resident #1's medication administration record (MAR) for November 2019	D 276		

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revealed:
-There was an entry for FSBS check twice daily and record results; scheduled at 7:00am and 8:00pm.
-There were no results documented from 11/01/19 to 11/30/19; there was documentation of the FSBS being done from 11/01/19 to 11/30/19.

Review of Resident #1's MAR for December 2019 revealed:
-There was an entry for FSBS check twice daily and record results; scheduled at 7:00am and 8:00pm.
-There were no results documented from 12/01/19 to 12/31/19; there was documentation of the FSBS being done from 12/01/19 to 12/31/19.

Review of Resident #1's MAR for January 2020 revealed:
-There was an entry for FSBS check twice daily and record results; scheduled at 7:00am and 8:00pm.
-There were no results documented from 01/01/20 to 01/02/20; there was documentation of the FSBS being done in the morning on 01/01/20.

Review of a blood sugar monitoring log for Resident #1 from November 2019 to January 2020 revealed:
-There were columns to record the date and the FSBS results for the morning and evenings.
-The results for the FSBS for November 2019 began on 11/06/19; there were 24 dates and 46 results documented.
-The results for the FSBS for December 2019 began on 12/01/19; there were 20 dates with results and there were 11 results without dates documented.
-The morning results for the FSBS for November 2019 ranged from 117 to 247; the evening results

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for the FSBS for November 2019 ranged from 114 to 299.
-There were no results documented for January 2020 on the log.

Review of lab results for Resident #1's A1C dated 07/16/19 revealed an A1C level of 10.8.

Observation of Resident #1's medication on hand on 01/02/20 at 5:0pm revealed there was a glucometer and a container of test strips.

Observation of Resident #1's glucometer on 01/03/20 at 9:00am revealed:
-The time and date on the glucometer were not set to the current date and time.
-There were twenty-six dates and thirty-nine readings on the glucometer.
-There were thirteen dates with single readings and there were thirteen dates with two readings.
-The dates did not run consecutively.
-The FSBS results ranged from 129 to 301.

Interview with Resident #1 on 01/02/20 at 3:59pm revealed:
-He did his own FSBS and he did the FSBS twice a day before breakfast and dinner.
-He wrote down the results on a sheet of paper in the office; no one watched him do the FSBS.

Telephone interview with a representative from the contracted pharmacy on 01/03/20 at 10:20am revealed:
-Test strips for Resident #1 had been dispensed on July 2019 and 50 strips were dispensed.
-Resident #1 had an order for test strips; the facility staff ordered test strips as needed from the pharmacy.

Telephone interview with a representative from

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D 276	Continued From page 12 primary care physician's (PCP) office on 01/03/20 at 11:03am revealed there was an order for FSBS check twice daily; the expectation was for facility staff to conduct the FSBS and keep accurate documentation of the results. Interview with the Administrator on 01/03/20 at 9:00am revealed: -Resident #1 did his own FSBS and documented the results on a log sheet. -She checked the log to make sure he documented the results correctly. -She did not check the log sheet with the glucometer readings to make sure the log sheet was correct.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the kitchen and food storage areas were clean and free of contamination including the reach-in refrigerator and freezer, and expired food in the dry pantry and refrigerator. The findings are: Observation of the dry storage area in the kitchen on 01/02/20 at 8:48am revealed:	D 282		

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D 282	Continued From page 13 -There were eight, 16 ounce (oz) tubs of ready to eat soup that had an expiration date of 12/24/19. -There were three, two-pound boxes of dry pasta that had an expiration date of 04/02/19. -There was a box of skillet dinner mix that had an expiration date of 08/29/19. -There were eight, two-pound boxes of dry lasagna pasta that had an expiration date of 02/15/19. -There were six boxes of boil in the bag rice that had an expiration date of 10/30/19. -There were nine boxes of grits that had an expiration date of 04/14/19. -There was a dented and rusted 28oz can of plumb tomatoes. -There were two boxes of 40 packages of fruit snacks that had an expiration date of 12/13/19. -There was a rusted waste basket sitting on the floor that had bottled water and fruit flavored drinks in it. -There was a two-pound bag of pecans that had an expiration date of 09/24/19. -There were two cans of large butter beans that were dented on the shelf. -There were two boxes of white rice that had an expiration date of 10/03/19. Observation of the reach-in refrigerator and freezer in the kitchen on 01/02/20 at 9:02am revealed: -There was a strong and unpleasant odor coming from the inside of the refrigerator. -There were dried food splatters on the inside of the door and walls of the refrigerator. -There was dried sticky and hard food spilled on the bottom of the refrigerator. -The inside of the two drawer compartments had dried food spilled on them and loose food debris. -There were three, one dozen cartons of fresh eggs in the shell that had an expiration date of	D 282		

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A VISION COME TRUE	220 HATCH STREET BURLINGTON, NC 27217

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D 282	Continued From page 14 09/18/19. -There was a plastic storage bag that had sliced deli meat that was not dated or labeled and had a brown and green discoloration; there was a cloudy liquid in the bottom of the storage bag. -There was a second plastic storage bag that contained a yellow liquid with bits of food that was not dated or labeled. -There was an eight-ounce package of swiss cheese that had an expiration date of 05/17/19. -There was an eight -ounce package of Havarti cheese that had blue and green mold on it and an expiration date of 05/17/19. -There were two bags of fresh carrots, one bag had a cloudy liquid in the bottom of it and the carrots in the second bag had turned brown with a brown liquid in the bottom. -There were two bags of chopped lettuce; the lettuce had turned a black, brown and dark green colored with an expiration date of 12/20/19. -The gaskets of the doors to the refrigerator and the freezer had black spots and film on them. -There was a case of 16 oz tubs of soup that had gotten wet and had mold on the bottom of the box with an expiration date of 12/24/19. Interview with the Administrator on 01/02/20 at 9:40am revealed: -She did the cooking for the residents and she did the daily cleaning in the kitchen including the refrigerator and the dry food storage area. -She did a deep cleaning including the refrigerator and dry storage areas every four months. -She knew the refrigerator needed to be cleaned, but she had not had time since before the holidays to do a deep cleaning in the kitchen. -She saw the molded cheese and expired eggs in the refrigerator on 01/02/20; she thought "someone" had put the food in the refrigerator,	D 282		

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D 282	Continued From page 15 but she did not know when or who would have put food in the refrigerator without her knowledge. -She had no idea who put the expired and spoiled food into the refrigerator; she had not seen the spoiled and expired food until that day. -The refrigerator was old and needed to be replaced. -She thought the food in the pantry was still "okay" to be used even though it was expired because it was all dry foods and they did not expire. -She was responsible for the sanitation and cleanliness of the kitchen, including the dry food storage and the refrigerator.	D 282		
D 300	10A NCAC 13F .0904(d)(3)(B) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (B) Fruit: Two servings of fruit (one serving equals 6 ounces of juice; ½ cup of raw, canned or cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide two servings of fruit each day to residents.	D 300		

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D 300	Continued From page 16 The findings are: Observation of the dry food pantry and the refrigerator on 01/02/20 at 8:48am revealed there was no fruit juice, fresh fruit or canned fruit available for the residents. Review of the posted menu in the kitchen for 01/02/20 revealed: -There was ¾ cup of juice and a half of a cup of fruit on the menu for breakfast. -There was a half of a cup of fruit on the menu for dinner. Observations on 01/02/20 of the lunch meal at 12:10pm and the dinner meal at 5:00pm revealed: -All residents were served 6 ounce drink pouches with straws attached to the back of the pouch; the drink pouches were a kiwi and strawberry flavored juice drink blend. -No fruit was served to the residents at either meal. Review of the nutritional label on the flavored drink pouch on 01/02/20 at 5:05pm revealed vitamin C was listed as a zero. The Administrator failed to provide receipts for food purchases. Interview with two residents on 01/02/20 at 8:32am revealed: -They got fresh fruit a long time ago but could not remember the last time they got fresh fruit. -There were times when they got canned apples or canned peaches after dinner or fruit in a pie for dessert. -They would like to eat fresh bananas or fresh	D 300		

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D 300	Continued From page 17 apples if they were offered. -They did not get orange juice or apple juice to drink at breakfast or with their meals. -They could not remember the last time they had juice to drink. Interview with two additional residents on 01/02/20 at 3:59pm revealed: -The residents never got fresh fruit; last week they got canned peaches. -They would like to eat more fruit; they would eat fruit if it was offered more often. -They did not get fruit every day. -They liked the fruit drink pouches they got for lunch that day; they had orange juice on 01/01/20, but that was the first time in a while. Interview with the Administrator on 01/03/20 at 7:50am revealed: -She knew she needed to have fruit for the residents to eat; she had not had fruit for the residents in two weeks. -She did not go to the grocery store; she made a list and gave it to various family members who would go to the local grocery stores for her. -The residents had not had orange juice since 12/31/19. -She thought the drink pouches were enough juice for the residents and were 100% fruit juice; she did not realize the drink puches were a juice blend and did not contain vitamin C. -She could not give a reason why the residents had not had fruit in over two weeks. -She did not know the residents were supposed to be served fruit twice a day and that one of the servings had to be 100% fruit juice.	D 300		
D 302	10A NCAC 13F .0904(d)(3)(D) Nutrition And Food Service	D 302		

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D 302	Continued From page 18 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following (D) Eggs: One whole egg or substitute (e.g., 2 egg whites or ¼ cup of pasteurized egg product) at least three times a week at breakfast. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to serve eggs to residents at least three times a week for breakfast. The findings are: Observation of the refrigerator in the kitchen on 01/02/20 at 8:48am revealed there were three, one dozen cartons of fresh eggs in the shell that had an expiration date of 09/18/19. Review of the weekly menu posted in the kitchen revealed eggs were on the menu every day at breakfast. Interview with two residents on 01/02/20 at 8:32am revealed they had cold cereal for breakfast that morning. Interview with two additional residents on 01/02/20 at 10:29am revealed: -They had not had eggs for breakfast in a long time; they thought they had eggs about a week ago for breakfast. -The Administrator cooked all the meals, but she gave them cold cereal for breakfast. -They would eat eggs if they were offered more often because they liked eggs.	D 302		

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D 302	Continued From page 19 Interview with a fifth resident on 0/02/20 at 3:59pm revealed: -He had cold cereal and toast for breakfast that morning; he ate cereal for breakfast two to three times a week. -He had eggs and grits five days ago, it was over the weekend; he thought he got eggs for breakfast one or two times a week. -The Administrator cooked for them, but in the morning she would run late and some of the residents had to leave for their "day programs" so she did not have time to cook breakfast. -He did not mind cold cereal, but he would like to eat eggs more often. -He liked eggs and would like to eat eggs for breakfast if they were offered. Interview with a sixth resident on 01/02/20 at 4:15pm revealed: -He left every morning at 8:00am because he had a job. -He usually only ate toast and drank coffee for breakfast; he had coffee and toast for breakfast that morning. -He thought it had been two or three weeks since eggs were served at breakfast. Interview with the Administrator on 01/02/20 at 4:26pm revealed: -She did not know the eggs in the refrigerator we expired; she would throw them out. -She cooked all the meals for the residents; there were four residents that went out for a day program every morning, so she served the residents cold cereal. Interview with the Administrator on 01/03/20 at 5:30pm revealed: -The eggs that had expired "came in" about two weeks ago.	D 302		

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D 302	Continued From page 20 -She used five dozen eggs about every other day; she would use over twenty eggs on the days she made eggs for breakfast. -The residents liked eggs and ate them when she cooked them. -She cooked eggs three or four times a week; they would eat eggs everyday if she cooked them, but she did not think eggs were good for the residents to eat every day. -She was familiar with the rule for eggs at breakfast three times a week.	D 302		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult 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, interviews and record reviews the facility failed to administer medications as ordered for 1 of 3 sampled residents (#2) with a vitamin supplement. The findings are: Review of Resident #2's current FL-2 dated 12/19/19 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), depression, hypertension, schizophrenic disorder, stroke, shortness of breath, dyspnea, and a history of	D 358		

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hiatal hernia.
-There was a medication order for vitamin D (used to treat vitamin deficiency) 1000 units take once daily.

Review of a physician order for Resident #2 dated 12/19/19 revealed Resident #2 was ordered a refill for Vitamin D.

Review of Resident #2's medication administration record (MAR) for November 2019 revealed:
-There was an entry for Vitamin D 1000 units take once daily; scheduled at 8:00am.
-Vitamin D was documented as administered at 8:00am from 11/01/19 to 11/30/19.

Review of Resident #2's MAR for December 2019 revealed:
-There was an entry for Vitamin D 1000 units take once daily; scheduled at 8:00am.
-Vitamin D was documented as administered at 8:00am from 12/01/19 to 12/31/19.

Review of Resident #2's MAR for January 2020 revealed:
-There was an entry for Vitamin D 1000 units take once daily; scheduled at 8:00am.
-Vitamin D was documented as administered at 8:00 am on 01/01/20.

Observation of Resident #2's medication on hand on 01/02/20 at 5:15pm revealed there was no Vitamin D available for administration.

Interview with Resident #2 on 01/02/20 at 4:10pm revealed he did not know what medications he took, but he took them twice a day because the Administrator gave them to him in a little cup.

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Telephone interview with a representative from the contracted pharmacy on 01/03/20 at 10:55am revealed:
-There was an active order for Vitamin D 1000 units take once daily; scheduled at 8:00am.
-The only dispense date for Vitamin D was on 02/01/2018 and thirty tables were dispensed.
-The Vitamin D was not on a cycle fill; the facility staff would need to call the pharmacy to reorder.
-An outcome from not taking Vitamin D as ordered could be detected with lab numbers; there would be not visible outcomes.

Telephone interview with a representative from Resident #2's primary care physician (PCP) office on 01/03/20 at 11:31am revealed:
-Resident #2 had a visit with his PCP on 12/19/19; there was an order to refill Resident #2's Vitamin D 1000 units take once daily.
-Resident #2 was ordered Vitamin D for his vitamin deficiency.
-The facility staff had not contacted the PCP's office concerning any medications for Resident #2.

Interview with the Administrator on 01/02/20 at 5:30pm revealed:
-She did not know where Resident #2's Vitamin D was; she thought he might have taken the last tablet that morning.
-She remembered giving Resident #2 his Vitamin D every day; she did not order refills because the pharmacy "automatically sent" the Vitamin D for Resident #2.

Interview with the Administrator on 01/03/20 at 8:55am revealed:
-She did not know Resident #2 had an order to refill his Vitamin D; the PCP's office should have let the pharmacy know he needed a refill.

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D 358	Continued From page 23 -She could not explain why Resident #2 had not had his Vitamin D refilled since February 2018.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .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	D 367		

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D 367	Continued From page 24 interviews, the facility failed to assure the medication administration records were accurate for 2 of 3 sampled residents including documentation for a medication used to lower blood glocose (#1) and a vitamin supplement (#2). The findings are: 1. Review of Resident #1's current FL-2 dated 07/16/19 revealed: -Diagnoses included diabetes, unspecified schizophrenia spectrum, history of alcohol use, history of cocaine use, and intellectual disability. -There was a medication order for NovoLog (used to lower blood glucose) inject 40 units in the morning and inject 40 units in the evening. Review of physician orders for Resident #1 dated 11/04/19 revealed a medication order for NovoLog inject 58 units in the morning and inject 54 units inject in the evening. Review of Resident #1's medication administration record (MAR) for November 2019 revealed: -There was an entry for NovoLog inject 50 units in the morning and inject 50 units in the evening; scheduled at 8:00am and 8:00pm. -There was a wavy line drawn through the entry for the month and there was no documentation NovoLog was administered. -There were no other entries for NovoLog on the MAR for November 2019. Review of Resident #1's MAR for December 2019 revealed: -There was an entry for NovoLog inject 58 units in the morning and inject 54 units in the evening; scheduled at 8:00am and 8:00pm.	D 367		

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-NovoLog was documented as administered twice a day for each day; the Administrator had initialed the medication as administered.

Review of Resident #1's MAR for January 2020 on revealed:
-There was an entry for NovoLog inject 58 units in the morning and inject 54 units in the evening; scheduled at 8:00am and 8:00pm.
-NovoLog was documented as administered on 01/01/20 at 8:00am; the Administrator had initialed the medication as administered.

Observation of Resident #1's medication on had on 01/02/20 at 5:05pm revealed there were 13 NovoLog pens, three pens were loose and not in a bag or a box and two boxes of five pens in each box.

Interview with Resident #1 on 01/02/20 at 3:59pm revealed:
-He administered his own NovoLog before his meals.
-No one was "a round" and no one watched him when he injected the NovoLog.

Telephone interview with a representative from the contracted pharmacy on 01/03/20 at 10:20am revealed:
-There was an active order for Resident #1 for NovoLog inject 58 units in the morning and inject 54 units in the evening; the date for the order was 11/04/19.
-The last dispense date for Resident #1's NovoLog pens was 11/04/19; two boxes of five pens and two pens in a resealable plastic bag.
-NovoLog was also dispensed on 08/21/19; two boxes of five pens and two pens in a resealable plastic bag.
-Each NovoLog pen would have lasted three

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days, the twelve pens would have lasted approximately 36 days.
-NovoLog was dispensed on 05/24/19; 10 pens were dispensed with an order for NovoLog inject 40 units in the morning and inject 40 units in the evening.
-Each NovoLog pen would have lasted approximately three and a half days; ten pens would have lasted approximately 37 days.
-When there was an order change for a medication in the middle of the month the facility staff would document the change on the MAR and the order would be updated on the MAR the following month.

Interview with the Administrator on 01/03/20 at 7:50am revealed:
-Resident #1 did his own NovoLog injections twice a day; she documented the NovoLog as administered after Resident #1 gave his own injection.
-She watched him give his own injections two to three times a week to make sure he did the injections.
-He had an order for self-administration of his NovoLog mediation; NovoLog was the only medication he could administer himself.
-She documented all of Resident #1's medication as administered at one time; she did not document each individual medication.
-She did not compare mediations to the MAR because she knew what medication Resident #1 took.
-Resident #1 took his NovoLog twice a day in November 2019; she did not know why it was not documented anywhere on the MAR.
-She had "crossed out" the NovoLog order for November 2019 because there was a dosage change; she did not know where she wrote the new order on the MAR.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A VISION COME TRUE	220 HATCH STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 27 2. Review of Resident #2's current FL-2 dated 12/19/19 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), depression, hypertension, schizophrenic disorder, stroke, shortness of breath, dyspnea, and a history of hiatal hernia. -There was a medication order for Vitamin D (used to treat vitamin deficiency) 1000 units take once daily. Review of a physician order for Resident #2 dated 12/19/19 revealed Resident #2 was ordered a refill for Vitamin D. Review of Resident #2's medication administration record (MAR) for November 2019 revealed: -There was an entry for Vitamin D 1000 units take once daily; scheduled at 8:00am. -The Administrator had initialed the medication as administered; Vitamin D was documented as administered thirty times out of thirty opportunities in November 2019; Review of Resident #2's MAR for December 2019 revealed: -There was an entry for Vitamin D 1000 units take once daily; scheduled at 8:00am. -The Administrator had initialed the medication as administered; Vitamin D was documented as administered thirty-one times out of thirty-one opportunities in December 2019. Review of Resident #2's MAR for January 2020 revealed: -There was an entry for Vitamin D 1000 units take once daily; scheduled at 8:00am. -The Administrator had initialed the medication as	D 367		

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D 367	Continued From page 28 administered; Vitamin D was documented as administered on 01/01/2020. Observation of Resident #2's mediation on hand on 01/02/20 at 5:15pm revealed there was no Vitamin D available for administering. Interview with Resident #2 on 01/02/20 at 4:10pm revealed he did not know what medications he took, but he took them twice a day because the Administrator gave them to him in a little cup. Telephone interview with a representative from the contracted pharmacy on 01/03/20 at 10:55am revealed: -There was an active order for Vitamin D 1000 units take once daily; scheduled at 8:00am. -The only dispense date for Vitamin D was on 02/01/2018 and thirty tables were dispensed. Interview with the Administrator on 01/02/20 at 5:30pm revealed: -She did not know where Resident #2's Vitamin D was; she thought he might have taken the last tablet that morning. -She remembered giving Resident #2 his Vitamin D every day. -She documented on the MAR after she had administered all of Resident #2's medication, sometimes she only documented on the MAR at the end of the day. -She did not compare the medications on the MAR to the medication she was administering.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications	D 375		

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D 375	Continued From page 29 (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews and interviews it was determind the facility failed to assure 1 of 1 sampled residents (#1) had an order to self-administer medications including a medication used to lower blood glucose levels. The findings are: Review of Resident #1's current FL-2 dated 07/16/19 revealed: -Diagnoses included diabetes, unspecified schizophrenia spectrum, history of alcohol use, history of cocaine use, and intellectual disability. -There was a medication order for NovoLog (used to lower blood glucose) inject 43 units in the morning and inject 43 units in the evening. Review of physician orders for Resident #1 dated 08/26/19 revealed a medication order for NovoLog inject 50 units in the morning and in the evening. Review of physician orders for Resident #1 dated 11/04/19 revealed a medication order for	D 375		

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D 375	Continued From page 30 NovoLog inject 58 units in the morning and inject 54 units in the evening. Review of Resident #1's medication administration record (MAR) for November 2019 revealed: -There was an entry for NovoLog inject 50 units in the morning and inject 50 units in the evening; scheduled at 8:00am and 8:00pm. -There was a line drawn through the entry for the month and there was no documentation NovoLog was administered from 11/01/19 to 11/30/19. -There were no other entries for NovoLog on the MAR for November 2019. Review of Resident #1's MAR for December 2019 revealed: -There was an entry for NovoLog inject 58 units in the morning and inject 54 units in the evening; scheduled at 8:00am and 8:00pm. -NovoLog was documented as administered twice a day from 12/01/19 to 12/31/19. Review of Resident #1's MAR for January 2020 on 01/02/20 revealed: -There was an entry for NovoLog inject 58 units in the morning and inject 54 units in the evening; scheduled at 8:00am and 8:00pm. -NovoLog was documented as administered on 01/01/20 at 8:00am. -NovoLog was not documented on the January 2020 as administered on 01/01/20 at 8:00pm and 01/02/20 at 8:00am. Observation of Resident #1's medication on hand on 01/02/20 at 5:05pm revealed: -There were three NovoLog pens without boxes. -There were two unopened NovoLog boxes; each box contained five pens and each pen contained 3ml prefilled syringes.	D 375		

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D 375	Continued From page 31 -The first unopened box of NovoLog pens had a despense date of 11/04/19 with the order on the box; inject 58 units in the morning and 54 units in the evening. -The second unopened box of NovoLog pens did not have a dispense date or order on it. Interview with Resident #1 on 01/02/20 at 3:59pm revealed: -He administered his own NovoLog before his meals; he went into the "office" and got his own medicine and did his own injection. -No one was "around" and no one watched him when he injected the NovoLog. -He injected 60 units into his stomach before meals two times a day. -He just turned the pen and stuck it into his stomach. Telephone interview with a representative from the contracted pharmacy on 01/03/20 at 10:20am revealed: -There was an active order for Resident #1 for NovoLog inject 58 units in the morning and inject 54 units in the evening; the date for the order was 11/04/19. -The last dispense date for Resident #1's NovoLog pens was 11/04/19; two boxes of five pens and two pens in a resealable plastic bag. -NovoLog was also dispensed on 08/21/19; two boxes of five pens and two pens in a resealable plastic bag. -Each NovoLog pen would have lasted three days, the twelve pens would have lasted approximately 36 days. -NovoLog was dispensed on 05/24/19; 10 pens were dispensed with an order for NovoLog inject 40 units in the morning and inject 40 units in the evening. -Each NovoLog pen would have lasted	D 375		

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D 375	Continued From page 32	D 375		

approximately three and a half days; ten pens would have lasted approximately 37 days.
-NovoLog was not on an auto or cycle fill and needed to be ordered when needed by the facility staff.
-Outcomes from not administering NovoLog as ordered could be uncontrolled blood glucose levels.

Telephone interview with a representative from Resident #1's primary care physician (PCP) office on 01/06/20 at 11:30am revealed Resident #1 did not have an order to self-administer any of his medications; the facility staff should be administering Resident #1's medication.

Interview with the Administrator on 01/03/20 at 7:50am revealed:
-Resident #1 did his own NovoLog injections; he did his own injections before he was admitted to the facility.
-He did his own injections twice a day; she unlocked "the office" and he would go in and get his pen and did his injection.
-She watched him give his own injections two to three times a week to make sure he did the injections and did them correctly.
-He had an order for self-administration of his NovoLog mediation; NovoLog was the only medication he could administer himself.
-She did not have any concerns with him administering his own NovoLog; he had not been evaluated by the PCP or a pharmacist to monitor his ability to self-administer his medication since he was admitted to the facility almost two years ago.
-The pharmacy "automatically sent" his NovoLog pens to the facility; she did not know how long a pen should have lasted.

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D 392	Continued From page 33	D 392		
D 392	10A NCAC 13F .1008(a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure there was an accurate accounting of and readily retrievable record of controlled substances including a medication used to prevent seizures for 1 of 3 sampled residents (#3). The findings are: Review of Resident #3's current FL-2 dated 12/27/19 revealed: -Diagnoses included hypernatremia, delirium, cellulitis in the right foot, constipation, seizures, catatonia, altered mental status, protein-calorie malnutrition and schizoaffective disorder-bipolar type. -There was a medication order for Vimpat (an anticonvulsant medication used to prevent partial seizures) 100mg take twice daily with meals. Review of a physicians order for Resident #3 dated 10/15/19 revealed Resident #3 was ordered Vimpat 100 mg take twice daily with food. Review of Resident #3's December 2019	D 392		

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D 392	Continued From page 34	D 392		

medication administration records (MARs) revealed:
-There was an entry for Vimpat 100mg take twice daily with food, scheduled at 8:00am and 5:00pm.
-There was documentation that Resident #3 was in the hospital from 12/16/19 to 12/27/19.
-There were no doses documented as administered from 12/16/19 to 12/27/19.

Review of a controlled substance log for Resident #3 revealed:
-Resident #3's name and instructions for Vimpat 100mg take twice daily was handwritten on the log and initialed by the Administrator.
-There was no documentation of a beginning tablet count.
-The start date was documented as 01/01/20 and one tablet was documented as sigened out in the morning and the Administrator had initialed beside the morning administration; there was no count or remaining tablet count.
-There were no tablets documented as signed out for the evening on 01/01/20 and there were no tablets documented as signedd in the morning or evening on 01/02/20.

There were no controlled substance logs available for review for Resident #3 for the months of November 2019 and December 2019.

Observation of Resident #3's medication on hand on 01/02/20 at 5:29pm revealed:
-There were two medication cards for Vimpat 100mg take twice daily with meals; one card was for the scheduled morning administration and the second card was for the scheduled evening medication administration.
-The evening medication card had a dispense date of 12/27/19 and 29 tablets were dispensed; 22 tablets remained in the card.

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D 392	Continued From page 35 -The back of each bubble had a date stamped on it; the evening medication card bubbles dated 12/27/19 through 01/03/20 had been punched and the tablets were removed from the medication card. Telephone interview with a representative from the facility's contracted pharmacy on 01/03/20 at 10:36am revealed: -The Administrator had not sent any of Resident #3's unused Vimpat back to the pharmacy. -Resident #3's Vimpat was dispensed in two medication cards; one card was for the morning administration and the other card was for the evening administration. -Vimpat was dispensed on 11/14/19 and 60 tablets were dispensed; 30 tablets per card. -Vimpat was dispensed on 12/14/19 and 59 tablets were dispensed; the evening card had 29 tablets. -The medication cards were sent to the facility before the medication needed to be started. -The medication cards had dates stamped onto the back of each bubble; the date on the bubble was the date the medication was supposed to be removed from the card and dispensed. -The November 2019 Vimpat would have begun on 11/27/19 and the December Vimpat would have begun administration on 12/27/19. Interview with the Administrator on 01/02/20 at 5:30pm revealed: -She was the only Medication Aide (MA) and she passed all the medication to the residents. -There was no policy for controlled medication or control logs. -She just wrote on the controlled log when she gave Resident #3 his medication; she did not document the remaining tablet count. -When Resident #3 was out to the hospital she	D 392		

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D 392	Continued From page 36 just "threw all the medication away" that he did not take while he was admitted to the hospital; she did not document the medications she discarded. -She guessed she could have sent the medication back to the pharmacy, but she did not think about it. -She had been trained by the pharmacy on how to use the control log, but she just wrote on the MAR most of the time. Based on observations, interviews and record reviews it was determinded Resident #3 was not interviewable. According to review of the documentation on the control log and despensing record there were five tablets of Vimpat unaccounted for.	D 392		
D 400	10A NCAC 13F .1009(a)(1) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (a) An adult care home shall obtain the services of a licensed pharmacist or a prescribing practitioner for the provision of pharmaceutical care at least quarterly. The Department may require more frequent visits if it documents during monitoring visits or other investigations that there are medication problems in which the safety of residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes the following: (1) an on-site medication review for each resident which includes the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and	D 400		

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D 400	Continued From page 37 medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and (B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and (C) documenting the results of the medication review in the resident's record. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to have medication reviews completed at least quarterly for 3 of 3 sampled residents (#1, #2, and #3). The findings are: 1. Review of Resident #1's current FL-2 dated 07/16/19 revealed diagnoses included diabetes, unspecified schizophrenia spectrum, history of alcohol use, history of cocaine use, and intellectual disability. Review of Resident #1's medication reviews revealed: -The last pharmacy review was completed on 05/09/19 by a pharmacist with the contracted pharmacy. -There were no quarterly pharmacy reviews available for review between 07/01/19 - 09/30/19 and 10/01/19-12/31/19.	D 400		

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D 400	Continued From page 38 Telephone interview with a representative from the facility's contracted pharmacy on 01/06/20 at 1:28pm revealed: -The staff from the pharmacy contacted the facility via telephone one week prior to the appointment with a date and time to come to the facility and conduct the quarterly reviews. -The pharmacy conducted reviews for five of the twelve residents at the facility; Resident #1 was included in the five residents they reviewed. -There should have been a review conducted on 10/29/19 but she did not know if the appointment for the review was kept; she had no record of a cancellation of the appointment. -The facility did not have a history of cancellations for appointments for the medication reviews. -The pharmacist was scheduled to conduct a medication review in January 2020 but had not set up a date and time yet. -The representative from the pharmacy would have left the documentation of the medication review in the resident's record. Refer to interview with the Administrator on 01/03/20 at 3:10pm. 2. Review of Resident #2's current FL-2 dated 12/19/19 revealed diagnoses included chronic obstructive pulmonary disease (COPD), depression, hypertension, schizophrenic disorder, stroke, shortness of breath, dyspnea, and a history of hiatal hernia. Review of Resident #2's medication reviews revealed: -The last pharmacy review was completed on 06/05/19 by a pharmacist with the contracted pharmacy. -There were no quarterly pharmacy reviews	D 400		

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available for review between 07/01/19 - 09/30/19 and 10/01/19-12/31/19.

Telephone interview with a representative from the facility's contracted pharmacy on 01/06/20 at 1:42pm revealed:
-The pharmacy reviewed six out of the twelve residents' medication at the facility; Resident #2 was one of the residents the pharmacy reviewed.
-The pharmacy tried to go to the facility every quarter for medication reviews; the Administrator was responsible for contacting the pharmacy to schedule the medication review appointments.
-He did not have a date on record for conducting a medication review at the facility.
-The facility had not contacted him for a review for the current quarter
-He did not have dates documented for the last three medication reviews; the reviews were left with the facility Administrator.
-The facility never cancelled or tried to reschedule dates for quarterly mediation reviews once the appointments were made.

Refer to interview with the Administrator on 01/03/20 at 3:10pm.

3. Review of Resident #3's current FL-2 dated 12/27/19 revealed diagnoses included hypernatremia, delirium, cellulitis in the right foot, constipation, seizures, catatonia, altered mental status, protein-calorie malnutrition and schizoaffective disorder-bipolar type.

Review of Resident #3's medication reviews revealed:
-The last pharmacy review was completed on 05/09/19 by a pharmacist with the contracted pharmacy.
-There were no quarterly pharmacy reviews

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D 400	Continued From page 40 available for review between 07/01/19 - 09/30/19 and 10/01/19-12/31/19. Telephone interview with a representative from the facility's contracted pharmacy on 01/06/20 at 1:28pm revealed: -The staff from the pharmacy contacted the facility via telephone one week prior to the appointment with a date and time to come to the facility and conduct the quarterly reviews. -The pharmacy conducted reviews for five of the twelve residents at the facility; Resident #3 was included in the five residents they reviewed. -There should have been a review conducted on 10/29/19 but she did not know if the appointment for the review was kept; she had no record of a cancellation of the appointment. -The facility did not have a history of cancellations for appointments for the medication reviews. -The facility was scheduled to conduct a medication review in January 2020 but had not set up a date and time yet. -The representative from the pharmacy would have left the documentation of the medication review in the resident's record. Refer to interview with the Administrator on 01/03/20 at 3:10pm. _____ Interview with the Administrator on 01/03/20 at 3:10pm revealed: -There were two pharmacies that were contracted with the facility. -There was a representative from each pharmacy that called her and set up dates and times for an appointment to come conduct the quarterly medication reviews. -The pharmacies had not kept up with the quarterly medication reviews; in the past she had to call both pharmacies two or three times to get	D 400		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001103	A. BUILDING: _____ B. WING _____	01/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A VISION COME TRUE	220 HATCH STREET BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 400	Continued From page 41 an appointment scheduled for the quarterly reviews. -She knew it had been over three months since the last quarterly reviews were done. -The representative from the pharmacies usually called her and cancelled the appointments and never rescheduled. -She did not know the last time the medication reviews were completed but she knew the reviews should have been done because they helped with some of the issues that happened with medications.	D 400		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to housekeeping and furnishings. The findings are: Based on observations, interviews and record reviews, the facility failed to maintain an	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D912	Continued From page 42 environment free of hazards with evidence of bed bugs in five resident rooms, by not properly treating and cleaning for bed bugs for an ongoing period of seven months, even after complaints from multiple residents, witnessing of live and dead bed bugs by the Administrator and an inspection report from the Department of Environmental Health. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. [Refer to Tag D079, 10A NCAC 13F .0306(a)(5) (Type B Violation)].	D912		