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 _____	08/15/2023

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 000	Initial Comments The Adult Care Licensure Section conducted an annual survey with an exit date of August 15, 2023.	D 000		
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, record reviews, and interviews, the facility failed to administer a medication for 1 of 3 sampled residents (#1) who was ordered an anti-viral medication. The findings are: Review of Resident #1's current FL-2 dated 01/05/23 revealed diagnoses included human immunodeficiency virus (HIV), major depressive disorder, hypertension, chronic kidney disease stage IV, and diabetes mellitus. Review of Resident #1's encounter form from the Primary Care Provider's (PCP) office revealed Resident #1 had a diagnosis of shingles. Review of a signed physician's order dated 06/22/23 revealed there was an order for Valacyclovir 1gm (used to treat shingles) three times a day for 7 days.	D 358		

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Review of Resident #6's June 2023 medication administration record (MAR) from 06/22/23 at 8:00pm to 06/30/23 at 8:00pm revealed:
-There was a handwritten entry for Valacyclovir 1gm three times daily with a scheduled administration time of 8:00am, 2:00pm and 8:00pm.
-There was documentation Valacyclovir 1gm was administered from 06/23/23 to 06/30/23 at 8:00am and from 06/22/23 to 06/30/23 at 8:00pm.
-There was no documentation Valacyclovir 1gm was administered at 2:00pm in June 2023.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/15/23 at 1:35pm revealed:
-The pharmacy had an order for Valacyclovir 1gm three times daily for 7 days dated 06/22/23.
-The pharmacy dispensed 21 tablets of Valacyclovir 1gm on 06/22/23.
-Valacyclovir was an anti-viral and was used to shorten the life of the virus and decrease the symptoms the resident was experiencing.

Interview with Resident #1 on 08/15/23 at 3:30pm revealed:
-He went to see his Primary Care Provider (PCP) about weeks ago.
-He was diagnosed with shingles and given a medication to take for a week.
-He was administered the medication in the morning and in the evening.
-The only medication he took after lunch was a scheduled medication, the orange pill, he had been taking for years.

Telephone interview with Resident #1's PCP on 08/15/23 at 4:02pm revealed:
-Resident #1 was seen in June 2023 and was

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D 358	Continued From page 2 diagnosed with shingles. -Resident #1 was started on Valacyclovir 1mg three times daily for 7 days. -She expected Resident #1 to be administered medications as ordered. -If Resident #1 did not receive Valacyclovir as ordered, it would take longer for the shingles to resolve. Interview with the medication aide on 08/15/23 at 2:15pm revealed: -She administered medications to Resident #1. -She took Resident #1 to the doctor in June 2023; he had shingles and was given a prescription. -She faxed the prescription to the pharmacy and made a handwritten entry on the current MAR, June 2023. -The medication was entered as Valacyclovir 1gm three times daily for 7 days and was scheduled for administration at 8:00am, 2:00pm, and 8:00pm. -She did not realize the Valacyclovir was not documented as administered at 2:00pm. -She thought she administered Valacyclovir at 2:00pm. Interview with the Administrator on 08/15/23 at 3:01pm revealed: -Resident #1 did not receive Valacyclovir 1gm at 2:00pm for 7 days. -She did not see the 2:00pm dose on the MAR. -She needed to be careful when administering medication to ensure she administered all medications as ordered.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 367		

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D 367	Continued From page 3 (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the medication administration record was accurate for 1 of 3 sampled residents (#1) including sliding scale insulin and a blood pressure medication. The findings are: Review of Resident #1's current FL-2 dated 01/05/23 revealed diagnoses included diabetes mellitus, hypertension, and chronic kidney disease stage IV. 1. Review of Resident #1's current FL-2 dated 01/05/23 revealed there was an order for Novolog sliding scale insulin (before meals and at bedtime as follows: 4 units for fingerstick blood sugar	D 367		

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D 367	Continued From page 4 (FSBS) readings 150-200; 6 units for FSBS readings 201-250; 8 units for FSBS readings 251 -300; 10 units for FSBS readings 301-350; and 12 units for FSBS readings 351-400. Review of Resident #1's June 2023 medication administration record (MAR) revealed: -There was an entry for Novolog sliding scale insulin 4 units for FSBS readings 150-200; 6 units for FSBS readings 201-250; 8 units for FSBS readings 251 -300; 10 units for FSBS readings 301-350; and 12 units for FSBS readings 351-400 with an administration time of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was documentation Novolog SSI was administered four times a day from 06/01/23 to 06/30/23. Review of Resident #1's July 2023 MAR revealed: -There was an entry for Novolog sliding scale insulin 4 units for FSBS readings 150-200; 6 units for FSBS readings 201-250; 8 units for FSBS readings 251 -300; 10 units for FSBS readings 301-350; and 12 units for FSBS readings 351-400 with an administration time of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was documentation Novolog SSI was administered four times daily from 07/01/23 to 07/31/23. Review of Resident #1's August 2023 MAR revealed: -There was an entry for Novolog sliding scale insulin 4 units for FSBS readings 150-200; 6 units for FSBS readings 201-250; 8 units for FSBS readings 251 -300; 10 units for FSBS readings 301-350; and 12 units for FSBS readings 351-400 with an administration time of 8:00am, 12:00pm, 5:00pm, and 8:00pm. -There was documentation Novolog SSI was	D 367		

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administered four times daily from 08/01/23 to 08/14/23 and on 08/15/23 at 8:00am.

Interview with the medication aide (MA) on 08/15/23 at 2:15pm revealed:
-She administered Resident #1's SSI when Resident #1's FSBS was greater than 150.
-She administered Novolog as ordered based on the FSBS readings.
-She did not administer Novolog SSI to Resident #1 if is FSBS readings was below 150.
-She did not realize she signed the MAR that she administered Novolog SSI each time she checked Resident #1's FSBS.

Interview with the Administrator on 08/15/23 at 3:01pm revealed:
-She signed the entry for administering Novolog SSI when Resident #1 FSBS was checked.
-She signed the MAR incorrectly.
-Resident #1 did not receive Novolog SSI if his FSBS reading was below 150.

2. Review of Resident #1's current FL-2 dated 01/05/23 revealed there was an order for amlodipine 10mg (used to treat elevated blood pressure) daily.

Review of Resident #1's signed physician's orders dated 07/11/23 revealed there was an order to decrease amlodipine to 5mg daily.

Review of Resident #1's July 2023 medication administration record (MAR) revealed:
-There was an entry for amlodipine 10mg daily with a scheduled administration time of 8:00am.
-There was documentation amlodipine 10mg was administered daily from 07/11/23 to 07/31/23.
-There was no entry for amlodipine 5mg and no documentation amlodipine 5mg was administered

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D 367	Continued From page 6 in 07/11/23 at 07/31/23. Observation of medication on hand on 08/15/23 at 12:00pm revealed: -Resident #1's medications were packed in a plastic 30-day multi-dose pack. -There were directions on the multi-dose pack that read "amlodipine 5mg take one tablet daily." -There was documentation on the plastic multi-dose pack that the multi-dose pack contained 30 amlodipine 5mg tablets. -There were 29 of 30 multi-dose packs remaining; one multi-dose pack had been punched. -There was documentation on each multi-dose pack that it contained a 5mg tablet of amlodipine. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/15/23 at 1:27pm revealed: -The pharmacy had an order for amlodipine 5mg daily dated 07/11/23. -The pharmacy dispenses a 30-day supply of medication in multi-dose packs. -When an order for a scheduled medication was changed, the pharmacy would pick up the multi-dose pack and repackage the remainder of the 30-days with the new dosage and return the multi-dose package to the facility the next day. -The pharmacy picked up Resident #1's multi-dose pack on 07/11/23, removed amlodipine 10mg from the multi -dose pack and re-packed the remainder of the month with amlodipine 5mg and returned the multi-dose pack to the facility on 07/12/23. -The pharmacy would enter the new order on the MAR to be printed on the upcoming month. -The facility was responsible for entering the changed order on the current MAR for the remainder of the current month.	D 367		

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D 367	Continued From page 7 Interview with the medication aid (MA) on 08/15/023 at 2:54pm revealed: -When an order was changed during the month, the pharmacy would pick the 30-day package of medications up and re-package the remainder of the month with the correct dosage. -Whoever was working when the new order came in was responsible for writing it on the MAR. -She did not know if she received the order or not. -She did not realize she was signing the MAR for the old dosage of amlodipine. -She did not realize the new order for amlodipine 5mg daily was not on the MAR from 07/11/23 to 07/31/23. Interview with the Administrator on 08/15/23 at 3:01pm revealed: -The pharmacy would pick up the 30-day pre-packaged multi-dose package, return to the pharmacy, remove the discontinued medications, add the new medication, reseat the multi-dose packs, and return the medication to the facility. -She was not aware amlodipine 5mg was not added to July 2023's MAR. -Amlodipine 10mg should have been discontinued by the MA or the Administrator and amlodipine 5mg should have been hand-written in on July 2023 MAR.	D 367		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (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:	D 375		

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D 375	Continued From page 8 (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 record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#1) had a physician's order to self-administer insulin. The findings are: Review of Resident #1's current FL-2 dated 01/05/23 revealed: -Diagnoses included diabetes mellitus, hypertension, and chronic kidney disease stage IV. -There was an order for Novolog sliding scale insulin (SSI) before meals and at bedtime as follows: 4 units for fingerstick blood sugar (FSBS) readings 150-200; 6 units for FSBS readings 201-250; 8 units for FSBS readings 251 -300; 10 units for FSBS readings 301-350; and 12 units for FSBS readings 351-400. -There was no self-administration order. Review of Resident #1's record on 08/15/23 revealed there was no self-administration evaluation completed for Resident #1. Interview with Resident #1 on 08/15/23 at 3:30pm revealed: -The medication aide (MA) administered his SSI	D 375		

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insulin; the Administrator did not.
-He administered his SSI insulin when the Administrator worked.
-The Administrator would bring me the insulin pens and supplies.
-He would place the needle on the pen and dial up the units of insulin to be administered.
-He did not know why the Administrator did not administer his insulin.
-He administered his SSI to himself before coming to this facility; he knew how to administer insulin.

Telephone interview with Resident #1's Primary Care Provider (PCP) on 08/15/23 at 4:02pm revealed:
-She did not know Resident #1 was self-administering his insulin.
-He did not have an order to self-administer medications.
-He had been a diabetic for many years; she felt sure he could administer his insulin.
-He did need someone to check him off to ensure he was competent to administer his insulin.

Interview with the Administrator on 08/15/23 at 3:01pm revealed:
-She did not understand the SSI order.
-Resident #1 knew how to administer his insulin and understood the SSI order.
-There was a copy of the SSI order on the front of the MAR notebook.
-She would give Resident #1 his Novolog insulin pen and he would give himself Novolog SSI as ordered.
-Resident #1 was administering his insulin before he was admitted to the facility.
-She did not know if Resident #1 had an order to self-administer his medications.

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D 375	Continued From page 10 Attempted telephone interview with the Licensed Health Professional Services (LHPS) Nurse on 08/15/23 at 4:04pm was unsuccessful.	D 375		