Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001167	A. BUILDING: ______ B. WING ______	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAKING VISIONS COME TRUE ASSISTED LIVI	625 LANE 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 and Complaint Investigation on November 29, 2023-November 30, 2023.	D 000	This plan of correction constitutes our written allegation of compliance for the deficiencies cited *submission of this plan correction is not an admission that the deficiency exist or that it is cited accurately. This plan is submitted to meet state and federal and guidelines.	
D 029	10A NCAC 13F .0302(a) Design And Construction 10A NCAC 13F .0302 Design And Construction (a) Any building licensed for the first time as an adult care home shall meet the requirements of the North Carolina State Building Code for new construction. All new construction, additions and renovations to existing buildings shall meet the requirements of the North Carolina State Building Code for I-2 Institutional Occupancy if the facility houses 13 or more residents or the North Carolina State Building Code requirements for Large Residential Care Facilities if the facility houses seven to twelve residents. The North Carolina State Building Code, all applicable volumes, which is incorporated by reference, including all subsequent amendments may be purchased from the Department of Insurance Engineering Division located at 322 Chapanoke Road, Suite 200, Raleigh, North Carolina 27603 at a cost of three hundred eighty dollars ($380.00). The facility shall also meet all of the rules of this Section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews the facility failed to provide residents care in the licensed facility where they were admitted for 2 of 5 sampled residents (#4, #5) as evidenced by a resident with behavioral problems staying overnight in an unlicensed building for 5 of 7 days each week (#4) and a resident who stayed	**D 029**	The administrator will be responsible for ensuring that no residents are allowed to enter the unlicensed building in questions called the “Visitor Center”. The Visitor Center was closed immediately on 12/11/2023. The administrator has ensured that the keys and sign-in log for use of this center have been removed to safe location to prevent use of the center. The administrator contacted the following who had previously reserved the Visitor Center for resident use to inform them that residents were no longer able to sign out of the licensed facility and enter the Visitor Center: • Family Members (who scheduled for holiday use) • Mobile Librarian • Peer Support Team • Pastor The administrator also posted a sign on the entrance of the Visitor Center stating that the “Visitor Center” is not to be utilized. The administrator also conducted staff facility training and re—orientation training on 12/27/2023, which addressed the use of the Visitor Center. The administrator will be responsible for monitoring the use of the Visitor Center.	12/11/2023 12/27/23

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tammie Staton, Adminstrator
TITLE
(X6) DATE: January 10, 2024

Reviewed and acknowledged 01/19/24. kg

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D 029	Continued From page 1 overnight in the same building for 2 days after cancer treatments (#5). The findings are: Observation of the facility on 11/29/23 at 5:30pm revealed: -When the back door to the facility was opened, there was a wooden porch, and directly across the porch, was a building with windows and an entrance door. -From the side yard outside of the facility it could be seen that the building had a separate roof and a separate heat pump. Interview with a medication aide (MA) on 11/29/23 at 5:30pm revealed: -The building behind the facility was used by staff and residents. -The building had a bedroom, kitchen, and bathroom. Telephone interview with the Administrator on 11/29/23 at 4:50pm revealed: -She referred to the building next to the facility as a "respite facility". -The building was separate from the facility and was used when a resident's family came to the facility. 1. Review of Resident #4's FL-2 dated 07/28/23 revealed diagnoses included type 1 diabetes, cerebral palsy, hemiplegia, developmental delay, and seizure disorder. Interview with a medication aide (MA) on 11/29/23 at 5:30pm revealed: -Resident #4 was in and out of that building (indicating the building attached to the facility by a porch since he was admitted to the facility.)	D 029		

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D 029	Continued From page 2	D 029		

-Every week, Resident #4 would be at the building for 3 days then the resident would come into the facility for 1-2 days to get the resident used to being around a crowd.
-Resident #4 would then go back to the building over the weekend to let the resident "calm back down."
-Resident #4 had one-on-one care from a [named] staff member while he was in the building.
-The [named] staff member providing the one-on-one care would prepare Resident #4's meals and administer his medication to him while he was in the building.
-Sometimes she or another MA would help with 1:1 care for Resident #4 if the [named] staff member was not available.

Interview with the same MA on 11/30/23 at 9:34am revealed:
-When Resident #4 stayed in the building he stayed with a [named] staff.
-Resident #4's medications were kept in the medication room in the facility.
-She would prepare Resident #4's medications and give them to the [named] staff to administer to Resident #4 when he stayed in the building.

Interview with a resident on 11/30/23 at 9:18am revealed:
-Resident #4 was his roommate at the facility.
-Resident #4 had stayed overnight in the building with a named staff because he walked away from the facility.
-Resident #4 only returned to the facility to eat his meals.

Telephone interview with the [named] staff member on 11/30/23 at 11:09am revealed:
-Resident #4 had been at "this" facility for about

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D 029	Continued From page 3 2-3 months. -He had been working with Resident #4 for over a year; he worked with Resident #4 at another facility. -He had never stayed with Resident #4 in the building "out back." -He did not know why anyone would say he had stayed with Resident #4 in the building at the back of the facility. -He had only worked with Resident #4 in the facility. Telephone interview with the Administrator on 11/29/23 at 4:50pm revealed: -Resident #4 spent six hours in the building at the back of the facility on 11/17/23 with a staff person when he returned to the facility after being incarcerated the night before, 11/16/23. -When Resident #4 was released from jail they were trying to get him transitioned back to her respite facility but before they could do that, Resident #4 brushed up against another staff member and went back to jail. -Resident #4 had been in her respite facility located at another address before moving to this facility and she was making adjustments to move the resident back to that respite facility. -Resident #4 had been in the building at the back of the facility where he stayed for about six hours before he walked away. 2. Review of Resident #5's FL-2 dated 04/19/23 revealed diagnoses included adenocarcinoma of the colon, iron deficiency anemia, bipolar disorder, seizures, orthostasis, syncope, and depression. Interview with Resident #5 on 11/30/23 at 8:09am revealed: -He stayed a couple of nights in the building with	D 029		

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D 029	Continued From page 4	D 029		

a staff member while he was going through cancer treatments and was sick.
-He would eat his meals in the facility and then return to the building.
-His medications were administered to him when he went to the facility to eat.
-Another resident stayed in the building with a staff member.
-During the day the resident spent the day in the facility and ate meals in the facility.
-The resident and the staff member stayed in the building at night.
-Staff could prepare meals and administer medication in the building.
-The building had a small living room, one bedroom, a kitchen, and a bathroom.

Interview with a resident on 11/30/23 at 9:18am revealed:
-Resident #5 had spent some time in the building and had only returned to the facility to eat meals.
-He did not know if staff stayed with Resident #5 when he stayed in the building.
-He did not know if anyone else stayed in the building and he had never been inside.

____

The facility failed to ensure residents who required assistance from staff were cared for in a licensed facility by moving a resident (#4) from the facility to the building at the back of the facility for multiple days at a time; the building had not been assessed to meet the minimal requirements of a licensed facility. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

____

The facility submitted a Plan of Protection in accordance with G.S.131D-34 for this violation on 12/11/23.

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D 029	Continued From page 5 CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 14, 2024.	D 029		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to have matching therapeutic diet menus for food service guidance for 1 of 1 sampled resident (#1) who had an order for an 1800 calorie American Diabetes Association (ADA) diet (#1). The findings are: Observation of the dining room on 11/29/23 at 8:16am revealed there were four weeks of regular weekly menus posted on a bulletin board and there was a one week no concentrated sweets diet (NCS) menu. Review of Resident #1's FL-2 dated 08/07/23 revealed: -Diagnoses included type 2 diabetes. -There was an order for an 1800 calorie ADA diet.	**D 296**	The administrator will be responsible for ensuring that all residents have matching therapeutic diets; the administrator has reviewed the all diet orders and all menus are in agreement with orders written by the PCP. The review of all orders was conducted on 12/01/2023. The administrator also conducted staff Facility Training and Re-orientation Training on 12/27/2023 which discussed the following: nutrition, food service, diet orders, and substitute menus. The administrator will ensure that monitoring of orders is completed monthly.	12/01/2023 12/27/23

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D 296	Continued From page 6	D 296		

Review of the facility's menus for the lunch meal on Wednesday, 11/29/23 revealed:
-The lunch menu for the regular diet was tomato rice soup, turkey sandwich on oatmeal bread with lettuce and tomato, sweet pickles, orange sections, vanilla pudding and 2% milk were to be served.
-The lunch menu for the NCS diet was turkey broccoli casserole, buttered parsley potatoes, a biscuit, sherbet, and 2% milk were to be served.
-There was not an 1800 ADA diet menu available for the staff to reference for guidance.

Observation of the lunch meal service on 11/29/23 at 11:54am revealed:
-Resident #1 was served a turkey sandwich with cheese on wheat bread, boiled potatoes, pickle spears, pineapple, a banana and a sprite.
-Resident #1 ate 100% of his meal.

Interview with Resident #1 on 11/29/23 at 7:58am revealed:
-He was not ordered a therapeutic diet or a diet for diabetes by his primary care provider (PCP).
-The only guidance he had been told by his PCP was not to eat artificial sweeteners.

Interview with a medication aide (MA) on 11/29/23 at 2:28pm revealed:
-She knew Resident #1 was ordered a diabetic diet because he was diabetic.
-She did not reference his FL-2 for a diet order.
-She followed the menu the Administrator had posted for her to follow.
-She did not serve sugar or artificial sweeteners to Resident #1 because he was diabetic and could not have them.
-She served him a sugar free carbonated beverage at lunch.

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D 296	Continued From page 7 Interview with the Administrator on 11/29/23 at 8:15am revealed: -Resident #1 was the only resident on a physician's ordered diet. -Resident #1 was ordered an ADA diet; 'basically just a diabetic diet". -She had a no concentrated sweets (NCS) weekly menu for the staff to follow. Telephone interview with the Administrator on 11/30/23 at 11:17am revealed: -Resident #1's PCP had told her to use the NCS diet menu for Resident #1. -The PCP was going to change Resident #1 to an NCS diet; she thought it was already an order on an after-visit report somewhere. Attempted telephone interview with Resident #1's PCP on 11/29/23 at 1:36am was unsuccessful.	D 296		
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: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to administer	D 358		

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D 358	Continued From page 8 medications as ordered for 3 of 4 sampled residents (#1, #3, #4) for medication used to lower blood sugars and a blood pressure medication (#1); an antidepressant medication (#3); and antipsychotic medication (#4). The findings are: 1. Review of Resident #3's current FL-2 dated 05/24/23 revealed: -Diagnoses included schizophrenia, diabetes, and hypertension. -There was an order for Effexor (an antidepressant) ER 150mg once daily. Review of Resident #3's November 2023 medication administration record (MAR) from 11/01/23-11/29/23 revealed: -There was an entry for Effexor 150mg ER take one capsule with breakfast with a scheduled administration time of 8:00am. -There was documentation Effexor 150mg ER was administered at 8:00am on 11/01/23-11/28/23. -There was a second entry for Effexor 150mg ER with a scheduled administration time of 8:00am and a start date of 11/11/23. -There was documentation Effexor 150mg ER was administered from 11/11/23-11/28/23 at 8:00am. Observation of Resident #3's medications on hand on 11/29/23 at 10:35am revealed: -There was a prescription bottle dispensed from the hospital pharmacy dated 11/09/23 for 15 tablets of Effexor 150mg; 3 tablets were remaining. -The daily multi-dose packets dated 11/28/23 dispensed from the facility's contracted pharmacy for Resident #3 did not contain Effexor.	**D 358**	The administrator is responsible for ensure that all medications are administered as order and as prescribed by the PCP. The administrator has completed the following: • Review of all resident charts • All residents have received a new FL-2 reviewed and signed by the PCP. • Pharmacy review conducted 12/28/23 • Contacted family members of private pay residents who have private insurance to discuss concerns. Mandatory training was conducted on the following dates: ✓ Medication Training (15hr) 12/2-12/3/2023 ✓ Psychotropic, Diabetes Overview, Insulin Administration, and Medication (6hr) 12/13/2023 ✓ Documentation Training (MAR, Control Log, Blood Pressure Log, and Blood Sugar Log) 12/7/2023 ✓ Diabetic Education 12/20/2023 ✓ Seizure Management Training 01/05/2024 The administrator has created a tracking process to track all new orders, discontinued orders and to monitor orders to ensure that all medications are available. The administrator has created at staff documentation log book to monitor all communication between providers, and family members. The administrator has conducted staff facility management training and re-orientation training on 12/27/2023; in an effort to ensure that all staff understands the process of managing orders, and medication. The administrator included in the tracking process that all medication orders are to be reviewed by 2 staff members. The administrator has created a new Blood Pressure and Blood Sugar log with more columns to that all parameters are easier to understand and self-explanatory.	12/5/23 12/2/23-01/5/24

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D 358	Continued From page 9 Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/29/23 at 11:31am revealed: -Twenty-eight tablets of Effexor were dispensed to Resident #3 on 08/10/23, 09/07/23, and 10/06/23. -There were no refills on Resident #3's Effexor after the 10/06/23 dispensing; a twenty-eight day supply. -The facility was notified on 09/20/23 that there were no refills and again on 10/27/23. Observation of the facility on 11/29/23 at 7:30am revealed Resident #3 was out of the facility. Review of Resident #3's emergency department (ED) hospitalist notes dated 11/08/23-11/10/23 revealed: -Resident #3 ran out of his psychiatric medication on 11/05/23. -Tonight, 11/08/23, Resident #3 had become agitated at the facility, and intentionally cut his hand with a razor. -A medication aide (MA) at the facility reported Resident #3 had been intentionally defecating on himself and had several violent outbursts. -Resident #3 had both auditory and visual hallucinations. -Resident #3 was told the only way to refill his medication was to see a psychiatrist in person which was why he was presented to the ED. Review of Resident #3's hospital after-visit summary dated 11/10/23 revealed: -Resident #3 was seen at the ED on 11/08/23 for a mental health evaluation and the diagnosis was documented as not taking medication as ordered; he was placed on observation. -There was an order for Effexor 150mg ER to	D 358	The administrator also conducted MAR training, Control log documentation training during the documentation class. Review of the logs and this process will be conducted monthly by the administrator and will be conducted bi-weekly by the designated Medication Aide. This process has also been included in the facility Quality Improvement Plan. The administrator also contracted with a training facility which will provide a PRN registered nurse to assist with the training and monitoring process.	

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D 358	Continued From page 10 take one capsule daily for 15 days. -Instructions were to get an appointment with an outpatient psychiatric provider. -The 15-day supply of Effexor was to bridge Resident #3 until his appointment. -Resident #3 was discharged back to the facility on 11/10/23. Review of Resident #3's hospital ED provider notes dated 11/28/23 revealed: -Per the triage note, Resident #3 was being seen for altered mental status. -The ED provider contacted staff at the facility and was told Resident #3 was seen at another local hospital ED that morning, 11/28/23, and was treated for a headache and was discharged after symptomatic management. -Resident #3 then had an unusual behavioral outburst where he yelled "help me" several times and was "out of control." -Historically, Resident #3 had been compliant with his medication, but staff noted that Resident #3 was beginning to run out of medication and was unsure of recent compliance. -Staff at the facility advised that behavioral outbursts such as Resident #3's outburst today, 11/28/23, were unusual for the resident. -Resident #3 was nonverbal today, 11/28/23, and it was unclear if this was volitional or not. -Facility staff had reported Resident #3 had a history of poor or rare verbal communication; this may represent psychiatric decompensation. -It was possible Resident #3 had worsening of his psychotic symptoms, but this was difficult to discern as this may have been the resident's baseline. -It was possible the behavioral outburst today may have been due to anxiety or agitation after recent discomfort and discharge from another ED.	D 358		

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D 358	Continued From page 11 -Resident #3 was noted to have a possible seizure in the ED and was transferred to the neuroscience intensive care unit (ICU). -On 11/29/23, Resident #3 was admitted for status epilepticus; Resident #3 had no history of seizures. -Previous schizophrenia medications would be continued. Interview with the MA on 11/29/23 at 12:29pm revealed Resident #3 was complaining of a headache and dizziness and she called emergency medical services (EMS). Telephone interview with a representative with EMS on 11/29/23 at 12:45pm revealed Resident #3 was transported to the local ED on 11/28/23 at 7:45am with the chief complaint as a headache. Telephone interview on 11/29/23 at 1:00pm with a representative with the hospital revealed Resident #3 presented to the ED with a complaint of a headache. Interview with the Administrator on 11/29/23 at 3:00pm revealed: -On 11/08/23, Resident #3 told her he was hearing voices, and they were telling him to cut himself. -He was having both illusions and delusions. -Resident #3 had been seeing a [named] mental health provider and after his October 2023 visit, the provider told him the provider no longer accepted his insurance. -Resident #3's family member had found him a new mental health provider, but when she talked to the family member yesterday, 11/28/23, the family member decided to change his insurance so his previous provider could see him. -Resident #3 had been given a 15-day supply of	D 358		

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Effexor on his last hospitalization and if the resident did not find a mental health provider, they were told the hospital would refill the medication again.
-She did not know Resident #3's Effexor had not been administered as ordered.
-Resident #3 told her on 11/28/23 that he had eaten two birds and a butterfly, and he deserved to die and was transported to a local hospital.
-When Resident #3 was discharged from the local hospital, the MA who was transporting the resident back to the facility called her and reported Resident #3 seemed worse; Resident #3 was "shaking, trembling and stating I need to die."
-She instructed the MA to transport the resident to another [named] ED.
-Resident #3 was still at the hospital as of today, 11/29/23.

Telephone interview with another Pharmacist at the facility's contracted pharmacy on 11/30/23 at 11:46am revealed:
-Effexor was an antidepressant.
-Effexor had a short half-life; within one day it could be out of the body.
-The longer Effexor was out of the body, the increased likelihood of behaviors and depression.
-If Effexor was missed even for one day Resident #3 could have a change in his condition.

Interview with the first MA on 11/30/23 at 2:07pm revealed:
-Resident #3 had run out of his psychiatric medication; it had been out over two weeks.
-They had been going back and forth trying to get a mental health provider to write an order for the medication.
-The last time Resident #3 went to the hospital, the resident had been out of his psychiatric

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D 358	Continued From page 13 medication for more than two weeks. -She thought it was in October 2023 she noticed Resident #3 was running out of his Effexor and the pharmacy staff stated there were no refills. -There had been insurance issues with finding a mental health provider for Resident #3. -She had called trying to locate a mental health provider for Resident #3 and Resident #3's family member was working on it also. -Resident #3 went through changes all the time so it was hard to know if any changes she had seen with Resident #3 were related to not being administered his medication. -She thought Resident #3 had "worse delusions" when he missed medication, "like him not talking got worse." Telephone interview with Resident #3's mental health provider's Licensed Practical Nurse (LPN) on 11/30/23 at 3:26pm revealed: -Resident #3 was a no-show at his January 2023 and March 2023 appointments. -On 03/20/23, they were notified Resident #3 had no refills on his medications. -The mental health provider wrote an order for a three-month supply of his mental health medications to bridge Resident #3 until he could be seen. -On 09/28/23, Resident #3 attended group therapy at the mental health facility. -On 10/05/23, Resident #3 was signed in to see a mental health provider virtually, but the resident did not stay on the virtual call. -On 10/17/23, she saw Resident #3, but the mental health provider did not see the resident because, through her assessment, the resident had been seen at the hospital and by his primary care provider (PCP) since his last visit with the mental health provider. -The mental health provider had requested she	D 358		

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review Resident #3's medical records from both the hospital and PCP before she saw the resident.
-Additional paperwork had to be completed before Resident #3 could be seen by the mental health provider.

Interview with Resident #3's PCP on 11/30/23 at 1:28pm revealed:
-She did not see Resident #3 for mental health.
-If Resident #3 missed his mental health medication for 3-5 days, his mental health symptoms could come back.
-Theoretically, if Resident #3 missed his Effexor, the symptoms for which the medication was ordered, would return.

Telephone interview on 11/30/23 at 5:09pm with a second MA revealed:
-Resident #3 ran out of his mental health medications on 11/05/23.
-On 11/08/23, Resident #3 could not talk, and was "just not himself"; he was "just lying in the bed", and had cut his hand with a razor, so she called EMS.
-Resident #3 did not have any medication was why the resident was "at the hospital now."
-She could not explain why Resident #3's Effexor dispensed on 11/09/23 and started on 11/11/23, still had medication remaining in the bottle when it was documented he had received the 15-day supply.

Attempted telephone interview with Resident #3's family member on 11/30/23 at 12:37pm was unsuccessful.

Attempted telephone interview with a third MA on 11/30/23 at 2:38pm was unsuccessful.

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Attempted telephone interview with Resident #3's previous mental health provider on 11/30/23 at 3:26pm was unsuccessful.

2. Review of Resident #4's FL2 dated 07/28/23 revealed diagnoses included type 1 diabetes, cerebral palsy, hemiplegia, developmental delay, and seizure disorder.

Review of Resident #4's Primary Care Provider's (PCP) orders dated 09/06/23 revealed an order to increase Resident #4's Abilify (an antipsychotic) to 15mg daily.

Review of Resident #4's PCP order dated 09/28/23 revealed:
-Resident #4 was seen in the office and was administered Abilify maintena 400mg IM.
-Resident #4 was to be administered Abilify maintena 400mg IM every four weeks.
-Resident #4 was to continue his Abilify tablets for 14 days then discontinue.

Review of Resident #4's September 2023 MAR revealed:
-There was an entry for Abilify 10mg take one tablet once daily with a scheduled administration time of 8:00am.
-Abilify 10mg was documented as administered daily at 8:00am from 09/01/23-09/12/23 and 09/17/23-09/30/23; exceptions were documented for 09/13/23-09/16/23.
-There was a handwritten entry for Abilify (no mgs were documented) take one tablet daily with a scheduled administration time of 8:00am.
-There was documentation Abilify was administered daily at 8:00am from 09/01/23-09/12/23 and 09/17/23-09/30/23; exceptions were documented for 09/13/23-09/16/23.

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D 358	Continued From page 16 Review of Resident #4's October 2023 MAR revealed: -There was an entry for Abilify 15mg take one tablet once daily with a scheduled administration time of 8:00am. -Abilify 15mg was documented as administered daily at 8:00am from 10/01/23-10/31/23. Observation of medications on hand on 11/30/23 revealed Resident #4 did not have any medications available to be reviewed. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/30/23 at 11:17am revealed: -The facility had dispensed 17 tablets of Abilify 10mg on 08/24/23 from an order dated 08/23/23. -On 09/06/23 an order was received to increase Resident #4's Abilify to 15mg. -Abilify 15mg was dispensed as follows; 5 tablets on 09/06/23, 17 tablets on 09/07/23, 11 tablets on 09/24/23, and 3 tablets on 10/06/23. -The order received on 09/06/23 was for a 30-day supply with no refills. -If Resident #4 also received the Abilify IM, it was a maintenance medication, and was then administered more Abilify than was ordered the resident could potentially have an overdose of the medication. -Resident #4 would have been more sedated. Interview with a medication aide (MA) on 11/30/23 at 9:25am and 2:07pm revealed: -She administered Resident #4's medications using the MAR and medications on hand. -She did not recall if Resident #4 had more than one dose of Abilify that was administered. -She did not know why Resident #4's Abilify was documented as administered for more than 14	D 358		

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days.

Telephone interview with another MA on 11/30/23 at 5:09pm revealed:
-She did not recall why Resident #4's Abilify was not discontinued.
-If she signed the MAR for the medication, she administered the medication.
-She could not answer any other questions without seeing the MARs.

Telephone interview with the Administrator on 11/30/23 at 11:17am and 4:05pm revealed:
-She did not know Resident #4 had been administered his Abilify after it had been discontinued.
-She was concerned Resident #4's medication had not been stopped as ordered.
-She was "big on the MAs being compliant with medications."
-The MAs were supposed to compare the label on the medication to the MAR to make sure the orders were correct before administrating all medications.
-Whoever transported the resident back from an appointment was responsible for dropping the prescription off at the pharmacy.
-The facility had an issue with the pharmacy stating faxes had not been received, so she implemented taking the prescription and/or discharge papers directly to the pharmacy.
-The staff member working at the facility when the resident returned was then responsible for processing the order which included calling the pharmacy to make sure the order had been received and entering the order in the MAR.

Based on observations, record reviews, and interviews Resident #4 had been discharged from the facility and was not interviewable.

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Attempted telephone interview with Resident #4's PCP on 11/30/23 at 2:41pm was unsuccessful.
3. Reviewof Resident #1's FL-2 dated 08/07/23 revealed diagnoses included type 2 diabetes, hypertension, and kidney disease.

a. Review of Resident #1's FL-2 dated 08/07/23 revealed there was an order for Novolin 100u/ml (an intermediate-acting insulin used to lower elevated blood sugar levels) inject subcutaneously three times a day before meals per sliding scale insulin (SSI); for finger stick blood sugar results (FSBS) from 150-200 give 4 units, 201-250 give 6 units, 251-300 give 8 units, 301-350 give 10 units, 351-400 give 12 units.

According to the American Diabetes Association (ADA), untreated hyperglycemia (high levels of glucose in the blood) could result in ketoacidosis (diabetic coma). Additionally, too much insulin could cause hypoglycemia (low levels of glucose in the blood) which could result in seizures or death.

Review of Resident #1's September 2023 medication administration record (MAR) revealed:
-There was an entry for Novolin 100u/ml three times a day per sliding scale; for FSBS results from 150-200 give 4 units, 201-250 give 6 units, 251-300 give 8 units, 301-350 give 10 units, 351-400 give 12 units scheduled before meals at 7:30am, 11:30am and 4:30am.
-There was documentation Resident #1's Novolin was administered 90 of 90 opportunities.
-There was no documentation of how many units of Novolin were administered.
-There were no other entries on Resident #1's September 2023 MAR for Novolin.

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Review of Resident #1's FSBS log for September 2023 revealed:
-The log had six columns and 31 rows.
-The first column had the days of the month; there was documentation of FSBS results in the next four columns.
-There was no documentation indicating what times the FSBS were done.
-Resident #1's FSBS results were documented 86 out of 90 opportunities, with a range from 71 to 383.
-There were 20 times Resident #1 should have been administered SSI based on documented FSBS results.

Review of Resident #1's October 2023 MAR revealed:
-There was an entry for Novolin 100u/ml three times a day per sliding scale; for FSBS results from 150-200 give 4 units, 201-250 give 6 units, 251-300 give 8 units, 301-350 give 10 units, 351-400 give 12 units scheduled before meals at 7:30am, 11:30am and 4:30am.
-There was documentation Resident #1's Novolin was administered 90 of 90 opportunities.
-There was no documentation of how many units of Novolin were administered.
-There were no other entries on Resident #1's October 2023 MAR for Novolin.

Review of Resident #1's FSBS log for October 2023 revealed:
-The log had six columns and 31 rows.
-The first column had the days of the month; there was documentation of FSBS results in the next four columns.
-There was no documentation indicating what times the FSBS were done.
-Resident #1's FSBS results were documented 86 out of 90 opportunities, with a range from 59 to

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D 358	Continued From page 20 332. -There were 21 times Resident #1 should have been administered SSI based on documented FSBS results. Review of Resident #1's November 2023 MAR from 11/01/23 to 11/29/23 revealed: -There was an entry for Novolin 100u/ml three times a day per sliding scale; for FSBS results from 150-200 give 4 units, 201-250 give 6 units, 251-300 give 8 units, 301-350 give 10 units, 351-400 give 12 units scheduled before meals at 7:30am, 11:30am and 4:30am. -There was documentation Resident #1's Novolin was administered 85 of 85 opportunities. -There was no documentation of how many units of Novolin were administered. -There were no other entries on Resident #1's November 2023 MAR for Novolin. Review of Resident #1's FSBS log for November 2023 from 11/01/23 to 11/29/23 revealed: -The log had six columns and 31 rows. -The first column had the days of the month; there was documentation of FSBS results in the next four columns. -There was no documentation indicating what times the FSBS were done. -Resident #1's FSBS results were documented 81 of 85 opportunities, with a range from 71 to 227. -There were 26 times Resident #1 should have been administered SSI based on documented FSBS results. Observation of Resident #1's medication on hand on 11/29/23 at 11:47am revealed: -Resident #1 had six vials of Novolin available for administration. -There were three vials of Novolin dispensed on	D 358		

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D 358	Continued From page 21 11/07/23 and were unopened; each vial had 10ml. -There were three vials of Novolin were dispensed on 07/21/23; each vial was opened and did not have open dates on them. -Two of the Novolin vials dispensed on 07/21/23 was approximately half full and the third vial was approximately quarter full. -There was a note on each vial to discard 42 days after opening. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/29/23 at 12:39pm revealed: -Resident #1 had an order for Novolin 100 units per millimeter administer three times a day per sliding scale; for FSBS results from 150-200 give 4 units, 201-250 give 6 units, 251-300 give 8 units, 301-350 give 10 units, 351-400 give 12 units scheduled before meals. -Three vials of Novolin 10mL were dispensed on 07/21/23 and three vials of Novolin 10mL were dispensed on 11/07/23. -It was difficult to say how long Resident #1's supply of Novolin soul have lasted because his order was SSI. -Resident #1's Novolin was not on a cycle fill; the facility notified the pharmacy when they needed a refill. -Novolin helped control Resident #1's blood glucose and was a longer acting insulin. -Resident #1's SSI should be administered correctly to prevent highs or lows in blood glucose levels. Interview with Resident #1 on 11/29/23 at 7:38am revealed: -He had FSBS checks four times daily; three times a day before he ate his meals. -The medication aide (MA) did his FSBS checks. -The MA did not always tell him what his FSBS	D 358		

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D 358	Continued From page 22 results were and he was not sure what his FSBS ranges were. -He knew he was supposed to be administered different amounts of insulin based on his FSBS results. -He did not always get and insulin injection when his FSBS was checked. -He thought he had an injection of insulin the night before, but he did not know how much. Interview with a MA on 11/29/23 at 10:48am revealed: -She reviewed the MAR prior to administering any medications. - "I know he gets 10 units [of Novolin] all three meals." -She administered Resident #1 his Novolin three times a day before meals based on the MAR and SSI based on his FSBS results, but she usually did not have to administer his SSI because his FSBS results were below 150. -She documented the administration of the 10 units of Novolin under the SSI entry in the MAR three times a day because that was where the order was. -She did a FSBS check for Resident #1 three times a day before meals and once before bedtime. -She only documented Resident #1's FSBS results and not the units of Novolin administered because "most times" he did not need his SSI because his FSBS results were low. -She thought the order for 10 units of Novolin and the SSI based on FSBS results were both on Resident #1's MAR under the entry for SSI. -She did not understand why the 10 units of Novolin were not on the MAR in addition to Resident #1's SSI order because she had seen the 10 units on the SSI entry. -The SSI order and the 10 units of Novolin had	D 358		

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D 358	Continued From page 23 been on the MAR together. -She did not know Resident #1's order for Novolin had ever changed. -She had been told by another MA to administer Resident #1 the 10 units of Novolin. -Resident #1's FSBS results had not been over 150 so he had not needed her to administer his SSI; only the 10 units of Novolin before every meal. -If the physician's order for the 10 units of Novolin were not on the MAR then she should not have administered the 10 units. -It "never dawned" on her that the 10 units of Novolin order had changed and was not on the MAR. -She was upset she had administered Resident #1 the 10 units of Novolin incorrectly; she would have to start looking at each resident's dosage and time of administration on the MAR every time she administered medication. Observation of the MA on 10/19/23 at 10:48am revealed she reviewed Resident #1's September 2023, October 2023 and November 2023 MAR. Second interview with the MA on 11/29/23 at 11:18am revealed: -She had called another MA and asked her about Resident #1's Novolin. -She was just confused and after speaking to another MA she learned she was wrong and only administered Resident #1 10 units of Novolin if Resident #1's FSBS results were over 150. -She was not told to document the number of units administered because she the sliding scale was to administer 10 units of Novolin when FSBS were over 150. -She documented the FSBS checks on the MAR under the SSI entry; that was why it was initialed every day.	D 358		

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D 358	Continued From page 24 Interview with a second MA on 11/30/23 at 12:47pm revealed: -He was not assigned to audit the MARs. -He thought the Administrator audited the MAR monthly. -He followed the orders on the entries on the MAR when he administered the residents' medications. -He compared the MAR to the medication before administering the medication. -If a resident had an order for FSBS then the results were documented on a separate log. -If a resident had an order for SSI then he followed the SSI order on the MAR and initialed the MAR but did not document the units of insulin administered unless there was an order to document the number of units administered. -If the resident did not have an order from the PCP to document the number of units of insulin administered for a SSI then he did not document anything. -He only initialed the MAR when he administered SSI. -If he documented when he did not have to administer insulin per SSI for Resident #1 it was an oversite. -If Resident #1 did not have the number of Novolin units administered per his SSI documented anywhere then he did not have an order from the PCP to document them. -The number of Novolin units administered per sliding scale did not matter as long as Resident #1's blood sugars came down. Telephone interview with the Administrator on 11/30/23 at 11:17am revealed: -The MAs were supposed to compare the label on the medication to the MAR to make sure the orders were correct prior to administrating all	D 358		

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medications.
-If the MAs had been reading the MAR then there would not have been any concerns but by not reading the MAR the medications might not be administered correctly.
-The number of units of Novolin administered for Resident #1's SSI should always be documented on a log she provided for the MAs.
-When Resident #1's FSBS results did not require SSI Novolin to be administered then the MAR should not have been initialed; if it was initialed then that indicates Novolin was administered to Resident #1.
-One of the MAs was assigned to audit the facility's MARs twice a quarter and bring any discrepancies to her attention.
-She was not aware Resident #1's Novolin units had not been documented anywhere; no one had brought it to her attention.
-She expected the MAs to follow the MAR and administer Resident #1's Novolin per the sliding scale.
-If the number of Novolin units administered to Resident #1 were not documented how would anyone know if they were correct?

Attempted telephone interview with Resident #1's primary care provider (PCP) on 11/29/23 at 1:36pm was unsuccessful.

b. Review of Resident #1's FL-2 dated 08/07/23 revealed there was an order for lisinopril (used to treat high blood pressure) 10mg once daily at bedtime and hold for systolic blood pressure (SBP) less than 100.

Review of Resident #1's September 2023 medication administration record (MAR) revealed:
-There was an entry for lisinopril 10mg hold for SBP less than 100 scheduled once daily at

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8:00pm.
-There was documentation Resident #1's lisinopril was administered 30 of 30 opportunities.
-There was no documentation of blood pressure results in the MAR or on a separate log to determine if the lisinopril needed to be held per the order.

Review of Resident #1's October 2023 MAR revealed:
-There was an entry for lisinopril 10mg hold for SBP less than 100 scheduled once daily at 8:00pm.
-There was documentation Resident #1's lisinopril was administered 31 of 31 opportunities.
-There was no documentation of blood pressure results in the MAR or on a separate blood pressure log to determine if the lisinopril needed to be held per the order.

Review of Resident #1's November 2023 MAR from 11/01/23 to 11/29/23 revealed:
-There was an entry for lisinopril 10mg hold for SBP less than 100 scheduled once daily at 8:00pm.
-There was documentation Resident #1's lisinopril was administered 28 of 28 opportunities.
-There was no documentation of blood pressure results in the MAR or on a separate log to determine if the lisinopril needed to be held per the order.

Observation of Resident #1's medication on hand on 11/29/23 at 11:47am revealed:
-Resident #1's medication was dispensed for seven days in a multidose package that was separated and labeled by the day of the week, the time of administration, the name and dose of the medication.
-Resident #1's lisinopril 10mg tablets were

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D 358	Continued From page 27 dispensed on 11/03/23 and five tablets were available for administration. Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/29/23 at 1:27pm revealed: -Resident #1 had a current order for lisinopril 10mg. -Lisinopril was used to lower blood pressure. -PCPs included parameters on medications, like the hold if SBP was less than 100, because the PCP did not want the resident's blood pressures to go too low. -The possible outcomes would depend on the individual resident, but if Resident #1's SBP was already less than 100 the lisinopril would definitely make it go lower. Interview with Resident #1 on 11/29/23 at 7:38am revealed: -He was ordered a blood pressure medicine, but he did not know the name or the dose. -The facility staff had never taken his blood pressure; it was only taken at his primary care provider's (PCP) office. -He did not know what his blood pressures normally were. Interview with a medication aide (MA) on 11/29/23 at 1:13pm revealed: -The facility staff never did blood pressure checks for the residents. -None of the residents in the facility had an order for blood pressure checks; there were no orders on the MAR for any blood pressure checks for residents. -None of the residents had blood pressure checks with medications or had medications with parameters for blood pressures.	D 358		

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D 358	Continued From page 28 Second interview with the MA on 11/30/23 at 9:34am revealed: -She followed the entries on the mar when administering residents their medications. -If there was an order for a medication with parameters to hold for SBP less than 100 then they would have to take a blood pressure because they would not be able to know whether to hold the medication or not without the blood pressure check. -She had not noticed the parameters for Resident #1's lisinopril on the MAR until today, 11/30/23. -Resident #1 did not have parameters with his lisinopril on the previous months' MARs; she had reviewed them with another MA. -She had never taken Resident #1's blood pressure so every time she had administered him his lisinopril 10mg in the past months she did not know what his blood pressures were. Interview with a second MA on 11/30/23 at 12:47pm revealed: -He was not assigned to audit the MARs and there was no schedule for auditing them. -He thought the Administrator audited the MAR monthly. -Blood pressure checks were not documented anywhere unless the resident's PCP ordered them to be documented. -If Resident #1's PCP ordered blood pressure checks to be done they were done but if the PCP did not order them to be documented then he did not document the results. -The initials on the MAR for the entry for Resident #1's lisinopril was all that was needed to document the blood pressures were done. -He followed the parameters to hold Resident #1's lisinopril and he initialed on the MAR; that was all that was required.	D 358		

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Telephone interview with the Administrator on 11/30/23 at 11:17am revealed:
-The MAs were supposed to document blood pressures on the MAR or on a separate log.
-When a blood pressure was part of a medication order then the blood pressure should be documented on the MAR entry for that medication.
-The MAs were supposed to read the MAR and compare it to the medication prior to administration.
-If the MAs had been reading the MAR then there would not have been any concerns but by not reading the MAR the medications might not be administered correctly.
-If Resident #1 was not having blood pressures checked prior to administering his lisinopril then he may have been administered it when he should not have been.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 11/29/23 at 1:36pm was unsuccessful.

____
The facility failed to administer medication as ordered for 3 of 4 sampled residents including a resident who had an order for an antidepressant; the resident was not administered the medication for 3 days due to the prescription having no refills and the resident was admitted to a local hospital for a psychiatric observation; the resident was then given a 15-day supply of the same medication that was not administered as ordered and the resident had another psychiatric event and was sent to a local hospital to be evaluated (#3); a resident (#1) who had an order for a sliding scale insulin but there was no documentation of the number of units administered per the sliding scale to ensure the insulin was administered correctly and an order

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D 358	Continued From page 30 for a blood pressure medication and to hold the medication if the systolic blood pressure was less than 100 but there was no documentation of any blood pressure readings to ensure the medication was administered correctly. This failure resulted in substantial risk of serious injury or serious abuse to the residents and constitutes a type A2 Violation. ____________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/30/23 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 30, 2023.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a medication aide (MA) observed residents take their medications. The findings are:	D 366		

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D 366	Continued From page 31 Observation of the dining room table on 11/29/23 at 7:25am revealed: -There were three tables in the dining room; two smaller tables sat two residents each and the third table had four seats. -There were four residents seated at the dining room at the table and one was standing up. -There was a medication aide (MA) in the dining room and she was talking to a resident. -There were empty multi-dose pill packages at multiple resident place settings. -One resident was observed taking the medication from the multidose package at his place setting. -Another resident was eating breakfast and his multidose package that contained tablets was lying on the table beside his plate. Interview with a resident on 11/29/23 at 7:37am revealed: -His medications were always lying beside his plate when he went to breakfast. -Evening medications were always lying on the table too with the evening snack. -No one watched the residents take their medications, the residents just knew to take them. Interview with a second resident on 11/29/23 at 7:48am revealed: -Medications were lying on the table at his plate when he got to the dining room. -They were told to "check their names." -The MA watched the residents take their medications. Interview with a third resident on 11/29/23 at 7:55am revealed: -His medication was always at his place setting at breakfast.	**D 366**	The administrator will ensure that all residents are monitored when receiving medication. The administrator conducted mandatory facility management training and re-orientation training on 12/27/2023; in an effort to ensure that all staff understands the administration of medication process. Mandatory training was conducted on the following dates: ✓ Medication Training (15hr) 12/2-12/3/2023 ✓ Psychotropic, Diabetes Overview, Insulin Administration, and Medication (6hr) 12/13/2023 ✓ Documentation Training (MAR, Control Log, Blood Pressure Log, and Blood Sugar Log) 12/7/2023 ✓ Diabetic Education 12/20/2023 ✓ Seizure Management Training 01/05/2024 The administrator also conducted MAR training, Control log documentation training during the documentation class. Review of the logs and this process will be conducted monthly by the administrator and will be conducted bi-weekly by the designated Medication Aide. This process has also been included in the facility Quality Improvement Plan. The administrator also contracted with a training facility which will provide a PRN registered nurse to assist with the training and monitoring process.	12/27/2023 12/2/23-01/5/24

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D 366	Continued From page 32 -The medication aide (MA) stood at the door and encouraged all the residents to take their medications so she could "go about her business." -The evening medications were administered with the same routine. Interview with a fourth resident on 11/29/23 at 8:05am revealed: -His medications were always at the table when he went to the dining room. -No one watched him take his medications, he just took the medication on his own. Interview with a fifth resident on 11/29/23 at 8:15am revealed: -He did not know how long the medications were at the table, the medications were lying at his plate when he got there. -No one watched him take his medications. -The same thing happened with his night medications. Interview with a sixth resident on 11/29/23 at 8:22am revealed: -His medications were always on the table. -No one watched him take his medications. Interview with the medication aide (MA) on 11/30/23 at 10:48am revealed: -She removed the residents' multidose medication cups for the day from the package all at one time. -She then documented on the medication administration record (MAR) she then placed the medication cups on the tables where the residents would sit. -The residents all came in at the same time for their meals and sat down. -The residents sat in the same seats at the tables	D 366		

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D 366	Continued From page 33 for every meal. -She would stand at the doorway to the dining room and watch all the residents take their medications at the same time. -She could not leave the medications on the table unsupervised and she could not leave the room until all the residents had taken their medications. -She looked in the medication cups to make sure the tablets were gone. -The residents opened the medication cups themselves. Telephone interview with the Administrator on 11/30/23 at 11:17am revealed: -The MA was supposed to verify the medication label to the MAR. -The residents were called into the day room 1 by 1 then the right resident was verified medication based on the name on the label of the multidose medication cup. -The MA would observe the resident take their medication and watch them swallow. -Once all the residents were administered their medications in the day room the MA would go back into the medication room and document the administration of the medications for all the residents on the MAR. -Sometimes the MA would administer medications to the residents in the same manner in the dining room. -The MA should not have placed the residents' medications on the dining room tables at the place setting before the residents came into the dining room. -Medication administration should be done one at a time and not as a group. -Medication should not be placed on the table before the residents were seated because someone could grab the wrong medication; it was a safety concern and would only work if the staff	D 366		

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D 366	Continued From page 34 stood in the dining room the entire time and watched everyone take their medications. -She was not aware they MA was documenting on the MAR prior to administering medications. -She was not aware the documentation of administration on the MAR was supposed to be done immediately following the medication administration to the resident; she thought the MA could document for all the residents after she had administered all the medications.	D 366		
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 35 interviews, the facility failed to ensure the accuracy of medication administration records (MARs) for 1 of 4 sampled residents (#3) related to a medication used to treat mania. The findings are: Review of Resident #3's current FL-2 dated 05/24/23 revealed: -Diagnoses included schizophrenia, diabetes, and hypertension. -There was no order for Lithium. Review of Resident #3's July 2023 medication administration record (MAR) from 07/25/23-07/31/23 revealed: -There was an entry for Lithium 300mg twice daily with a scheduled administration time of 8:00am and 5:00pm. -Lithium was documented as administered from 07/25/23-07/31/23 at 8:00am and on 07/30/23 at 5:00pm; 8 capsules were documented as administered. Review of Resident #3's August 2023 MAR revealed: -There was an entry for Lithium 300mg twice daily with a scheduled administration time of 8:00am and 5:00pm. -Lithium was documented as administered 08/01/23-08/31/23 at 8:00am and 5:00pm; 62 capsules were documented as administered. Review of Resident #3's September 2023 MAR revealed: -There was a hand-written entry for Lithium 300mg twice daily with a scheduled administration time of 8:00am and 5:00pm. -Lithium was documented as administered 09/01/23-09/30/23 at 8:00am and 5:00pm; 59	**D 367**	The administrator is responsible for ensure that all medications are administered as order and as prescribed by the PCP. The administrator has completed the following: • Review of all resident charts • All residents has received a new FL-2 reviewed and signed by the PCP. • Pharmacy review conducted 12/28/23 • Contacted family members of private pay residents who has private insurance to discuss concerns. Mandatory training was conducted on the following dates: ✓ Medication Training (15hr) 12/2-12/3/2023 ✓ Psychotropic, Diabetes Overview, Insulin Administration, and Medication (6hr) 12/13/2023 ✓ Documentation Training (MAR, Control Log, Blood Pressure Log, and Blood Sugar Log) 12/7/2023 ✓ Diabetic Education 12/20/2023 ✓ Seizure Management Training 01/05/2024 The administrator has created a tracking process to track all new orders, discontinued orders and to monitor orders to ensure that all medications are available. The administrator will ensure that this process is followed and has designated a Medication Aide who will monitor this process on a bi-weekly basis; the administrator will monitor monthly.	12/5/2023 12/2/23-01/5/24

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MAKING VISIONS COME TRUE ASSISTED LIVI	625 LANE 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 36 capsules were documented as administered. Observation of Resident #3's medications on hand on 11/29/23 at 10:34am revealed there was no Lithium 300mg available to be administered. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/29/23 at 11:31am revealed: -Resident #3's Lithium 300mg twice a day was filled from the resident's hospital discharge summary. -Lithium 300mg was dispensed on 07/25/23 for 38 capsules, 08/10/23 for 28 capsules, and 08/24/23 for 28 capsules; 94 capsules were dispensed. -The pharmacy staff tried contacting Resident #3's hospitalist who wrote the order, but a prescription was not received, and no further Lithium was dispensed for Resident #3. Comparison of Resident #3's MARs and the total amount of dispensed Lithium revealed Lithium was documented as administered 129 times and only 94 capsules were dispensed. Interview with a medication aide (MA) on 11/30/23 at 2:07pm revealed: -She wrote in Lithium for Resident #3 in error. -Resident #3's Lithium was discontinued in August 2023. -She thought Lithium was in Resident #3's multidose pill package but it would not have been since it was discontinued. -When the medication was delivered each month, whoever was working should compare the medication dispensed to the new MAR and the previous month's MAR to make sure they matched. -She documented Resident #3's Lithium because	D 367		

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D 367	Continued From page 37 she assumed it was in the multidose package. Telephone interview with the Administrator on 11/30/23 at 4:05pm revealed: -She did not know Resident #3's Lithium had been documented as administered when there would have been no medication available to administer. -At the end of each month when the next cycle of medication was delivered, the MAs had a three-step process to verify the MAR and medications dispensed were correct. -The here-step process included making sure there was an order for all medications on the MAR. -If there was a medication listed on the MAR and a copy of the order was not in the resident's record, the MA should call the pharmacy. -The MA was then to look at the medication dispensed and ensure the medication had been dispensed correctly based on the order and the MAR. - The MAs were supposed to compare the label on the medication to the MAR to make sure the orders were correct before administrating all medications.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by:	D 392		

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D 392	Continued From page 38 TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt, administration, and disposition of a controlled medication for 1 of 2 sampled residents (#4) related to a schedule V seizure medication, a schedule IV seizure medication, and a schedule IV anti-anxiety medication. The findings are: 1. Review of Resident #4's FL-2 dated 07/28/23 revealed diagnoses included type 1 diabetes, cerebral palsy, hemiplegia, developmental delay, and seizure disorder. Telephone interview with the Administrator on 11/30/23 at 4:51pm revealed: -Resident #4 went to the hospital on 11/17/23 and at discharge was going to an inpatient mental health facility per the resident's guardian. -Resident #4 was an emergency discharge from the facility because the resident had thoughts of self-harm and behavior issues. -Resident #4's medication was returned to the pharmacy. a. Review of Resident #4's FL-2 dated 07/28/23 revealed an order for Lacosamide (a schedule V controlled substance used to treat seizures) 200mg twice daily. Review of Resident #4's Primary Care Provider's (PCP) order dated 09/28/23 revealed the morning dose of Lacosamide was to be discontinued and continue with the pm dose. Telephone interview with a Pharmacist at the	**D 392**	The administrator will ensure that all control substances are administered, documented and count log is completed correctly. The administrator has completed the following: • Review of all resident charts • All residents has received a new FL-2 reviewed and signed by the PCP. • Pharmacy review conducted 12/28/23 Mandatory training was conducted on the following dates: ✓ Medication Training (15hr) 12/2-12/3/2023 ✓ Psychotropic, Diabetes Overview, Insulin Administration, and Medication (6hr) 12/13/2023 ✓ Documentation Training (MAR, Control Log, Blood Pressure Log, and Blood Sugar Log) 12/7/2023 ✓ Diabetic Education 12/20/2023 ✓ Seizure Management Training 01/05/2024 The administrator has created a tracking process to track all new orders, discontinued orders and to monitor orders to ensure that all medications are available. The created at staff documentation log book to monitor all communication. The administrator conducted staff Facility Management Training on 12/27/2023; in an effort to ensure that all staff understands the process of documenting, administering and managing medication orders. MAR and control log training was also discussed during the documentation training. The administrator will ensure that this process is followed band has designated Medication Aide who will monitor this process on a bi-weekly basis	01/05/2023 12/2/23-01/5/24

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D 392	Continued From page 39 facility's contracted pharmacy on 11/30/23 at 11:17am revealed: -Sixty tablets of Lacosamide 200mg were dispensed on 07/19/23 and 09/19/23 with the directions to administer one tablet every 12-hours. -Controlled substance count sheets (CSCS) were sent with each dispensing of Lacosamide. Review of Resident #4's CSCS for Lacosamide 200mg revealed: -There were 2 CSCS each for 60 tablets dispensed on 07/19/23 and 09/19/23. -The CSCS dated 07/19/23 had a start date of 07/19/23 and the last date the medication was signed as administered was 08/17/23 and a total of 44 tablets of 60 were documented and signed as administered; there were 16 tablets unaccounted for. -The CSCS dated 09/19/23 had a start date of 09/20/23 and the last date the medication was signed as administered was 11/16/23 and a total of 55 tablets of 60 were documented and signed as administered; there were 5 tablets unaccounted for. Review of Resident #4's medication administration records (MAR) revealed: -There was no MAR available to be reviewed for July 2023 and August 2023. -The September 2023 MAR had an entry to administer Lacosamide 200mg every 12 hours with a scheduled administration time of 8:00am and 8:00pm. -There were 55 doses of Lacosamide documented as administered.; exceptions were documented for 09/15/23-09/17/23. -The October 2023 MAR had an entry to administer Lacosamide 200mg every 12 hours with a scheduled administration time of 8:00am	D 392		

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D 392	Continued From page 40 and 8:00pm; 62 doses of Lacosamide were documented as administered. -The November 2023 MAR from 11/01/23-11/15/23 had an entry to administer Lacosamide 200mg every 12 hours with a scheduled administration time of 8:00am and 8:00pm; 30 doses of Lacosamide were documented as administered. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/30/23 at 2:34pm revealed there was no documentation Resident #4's Lacosamide 200mg was returned to the pharmacy. Review of Resident #4's CSCS, dispensed medication, and returned medication revealed 120 doses of Lacosamide tablets were dispensed, 99 tablets were documented as administered and no tablets were returned to the pharmacy leaving 21 tablets of Lacosamide 200mg unaccounted for. Refer to the telephone interview with a MA on 11/30/23 at 11:09am. Refer to the interview with a second MA on 11/30/23 at 4:27pm. Refer to the telephone interview with a third MA on 11/30/23 at 5:09pm. Refer to the telephone interview with the Pharmacist on 11/30/23 at 11:17am. Refer to the telephone interview with the Administrator on 11/30/23 at 4:05pm. b. Review of Resident #4's FL-2 dated 07/28/23 revealed an order for Clobazam (a schedule IV	D 392		

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controlled substance used to treat seizures) 10mg in the morning and 15mg at bedtime.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/30/23 at 11:17am and 4:58pm revealed:
-Resident #4 had an order dated 07/20/23 for Clobazam 10mg, one tablet, scheduled in the morning, and Clobazam 15mg, one and a half tablets, scheduled at bedtime; the order was for a 30-day supply.
-Resident #4's Clobazam was dispensed in two single-dose bubble medication packages on 07/20/23.
-A thirty-day supply of Clobazam 10mg was dispensed with one tablet in a bubble package and the Clobazam 15mg was dispensed with a tablet and a half in a second bubble package.
-The half tablets were included on the tablet count as whole tablets; a thirty-day supply of just half tablets was counted as 15 tablets on the package label so the total count for a tablet and a half would have been 45 tablets.
-CSCS were sent with each dispensing of Clobazam.

Review of Resident #4's CSCS for Clobazam 10mg revealed:
-There were 2 CSCS each for a 30-day supply dispensed on 07/20/23 with the directions to administer one tablet in the morning and one and a half tablets at bedtime.
-The CSCS for the bedtime dose had a start date of 07/20/23 and the last date the medication was signed as administered was 08/16/23 and a total of 23 doses of 30 were documented and signed as administered; there were 7 doses unaccounted for.
-The CSCS for the morning dose had a start date of 07/21/23 and the last date the medication was

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signed as administered was 08/23/23 and a total of 24 doses of 30 were documented and signed as administered; there were 6 doses unaccounted for.

Review of Resident #4's MARs revealed there was no MAR available to be reviewed for July 2023 and August 2023.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/30/23 at 2:34pm revealed there was no documentation that Resident #4's Clobazam 10mg was returned to the pharmacy.

Review of Resident #4's CSCS, dispensed medication, and returned medication revealed 60 doses of Clobazam 10mg tablets were dispensed, 47 doses were documented as administered and no tablets were returned to the pharmacy leaving 13 doses of Clobazam 10mg unaccounted for.

Refer to the telephone interview with a MA on 11/30/23 at 11:09am.

Refer to the interview with a second MA on 11/30/23 at 4:27pm.

Refer to the telephone interview with a third MA on 11/30/23 at 5:09pm.

Refer to the telephone interview with the Pharmacist on 11/30/23 at 11:17am.

Refer to the telephone interview with the Administrator on 11/30/23 at 4:05pm.

c. Review of Resident #4's FL-2 dated 07/28/23 revealed an order for Klonopin (a schedule IV

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controlled substance used to prevent and treat anxiety and agitation) 0.5mg one tablet twice a day as needed (PRN).

Review of Resident #4's Primary Care Provider's (PCP) order dated 08/23/23 revealed an order to change the PRN Klonopin 0.5mg to scheduled twice daily and add a Klonopin 0.5mg once daily PRN.

Review of Resident #4's PCP order dated 09/06/23 revealed an order to increase Klonopin 0.5mg to 1mg scheduled twice daily and add in Klonopin 0.5mg once at school as needed and once at the facility as needed.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/30/23 at 11:17am revealed:
-Sixty tablets of Klonopin 0.5mg were dispensed on 07/19/23 with the directions to administer one twice daily PRN.
-Sixty tablets of Klonopin 0.5mg were dispensed on 08/24/23 with the directions to administer twice daily.
-Thirty tablets of Klonopin 0.5mg were dispensed on 08/31/23, 09/25/23, and 10/20/23 with the directions to administer PRN.
-The CSCS were sent with each dispensing of Klonopin.

Review of Resident #4's CSCS for Klonopin revealed:
-There was a CSCS for 60 tablets of Klonopin 0.5mg dispensed on 07/19/23; 15 tablets were documented as administered leaving a balance of 45 tablets.
-There was a CSCS for 60 tablets of Klonopin 0.5mg dispensed on 08/24/23; 32 tablets were documented as administered leaving a balance of

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D 392	Continued From page 44 28 tablets. -There was a CSCS for 30 tablets of Klonopin 0.5mg dispensed on 08/31/23 with the direction to administer one tablet daily at the day program as needed for anxiety/hallucinations; 1 tablet was documented as administered leaving a balance of 29 tablets. Review of Resident #4's MARs revealed: -There was no MAR available to be reviewed for July 2023 and August 2023. -The September 2023 MAR had an entry to administer Klonopin 0.5mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There were 56 doses of Klonopin 0.5mg documented as administered; exceptions were documented for 09/14/23-09/16/23. -There was a second entry for Klonopin 0.5mg twice daily as needed; there was no documentation that PRN Klonopin 0.5mg was administered. -The October 2023 MAR had an entry to administer Klonopin 0.5mg once daily as needed; there was no documentation that PRN Klonopin 0.5mg was administered. -There was a second entry for Klonopin 0.5mg twice daily as needed; there was no documentation that PRN Klonopin 0.5mg was administered. -The November 2023 MAR from 11/01/23-11/15/23 had an entry to administer Klonopin 0.5mg once daily as needed; there was no documentation that PRN Klonopin 0.5mg was administered. -There was a second entry for Klonopin 0.5mg twice daily as needed; there was no documentation that PRN Klonopin 0.5mg was administered.	D 392		

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D 392	Continued From page 45 Review of Resident #4's medications returned to the pharmacy dated 09/14/23 revealed 28 tablets of Klonopin 0.5mg dispensed on 08/24/23 were returned to the pharmacy and the count was verified and signed by the pharmacy technician. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/30/23 at 2:34pm revealed: -Thirty-two of sixty tablets of Resident #4's Klonopin 0.5mg dispensed on 07/19/23 were returned to the pharmacy on 11/30/23. -Four of 30 tablets of Resident #4's Klonopin 0.5mg dispensed on 08/31/23 were returned to the pharmacy on 11/30/23. -Thirty of thirty tablets of Resident #4's Klonopin 0.5mg dispensed on 10/20/23 were returned to the pharmacy on 11/30/23. -There were no other doses of Resident #4's Klonopin returned to the pharmacy. Review of Resident #4's CSCS, dispensed medication, and returned medication revealed 210 tablets of Klonopin 0.5mg were dispensed, 48 tablets were documented as administered and 94 tablets were returned to the pharmacy leaving 68 tablets of Klonopin 0.5mg unaccounted for. Refer to the telephone interview with a MA on 11/30/23 at 11:09am. Refer to the interview with a second MA on 11/30/23 at 4:27pm. Refer to the telephone interview with a third MA on 11/30/23 at 5:09pm. Refer to the telephone interview with the Pharmacist on 11/30/23 at 11:17am.	D 392		

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Refer to the telephone interview with the Administrator on 11/30/23 at 4:05pm.

d. Review of Resident #4's PCP order dated 09/06/23 revealed an order to increase Klonopin 0.5mg to 1mg scheduled twice daily.

Telephone interview with a Pharmacist at the facility's contracted pharmacy on 11/30/23 at 11:17am revealed:
-Sixty tablets of Klonopin 1mg were dispensed on 09/07/23 with the directions to administer twice daily.
-Thirty-eight tablets of Klonopin 1mg were dispensed on 10/18/23 with the directions to administer twice daily.
-A total of 98 Klonopin 1mg were dispensed between 09/07/23-10/18/23.
-The controlled substance count sheets (CSCS) were sent with each dispensing of Klonopin.

Review of Resident #4's CSCS for Klonopin revealed:
-There was a CSCS for 60 tablets of Klonopin 1mg dispensed on 09/07/23 with the directions to take one tablet twice daily; one tablet was documented as administered leaving a balance of 59 tablets.
-There was a CSCS for 38 tablets of Klonopin 1mg dispensed on 10/18/23 with the directions to take one tablet twice daily; the count started with sixty and ended with 24.
-On the 10/18/23 CSCS there were thirty-six tablets documented as administered leaving a balance of 2 tablets.

Review of Resident #4's MARs revealed:
-There was no MAR available to be reviewed for July 2023 and August 2023.
-The September 2023 MAR had an entry to

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administer Klonopin 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There were 42 doses of Klonopin 1mg documented as administered; exceptions were documented for 09/14/23-09/16/23.
-The October 2023 MAR had an entry to administer Klonopin 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm; 62 doses of Klonopin 1 mg were documented as administered.
-The November 2023 MAR from 11/01/23-11/15/23 had an entry to administer Klonopin 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm; 30 doses of Klonopin 1mg were documented as administered.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 11/30/23 at 2:34pm revealed:
-Eight tablets of Resident #4's Klonopin 1mg dispensed on 10/18/23 were returned to the pharmacy on 11/30/23.
-There were no other doses of Resident #4's Klonopin returned to the pharmacy.

Review of Resident #4's CSCS, dispensed medication, and returned medication revealed 98 tablets of Klonopin 1mg were dispensed, 37 tablets were documented as administered, and 8 tablets were returned to the pharmacy leaving 53 tablets of Klonopin 1mg unaccounted for.

Refer to the telephone interview with a MA on 11/30/23 at 11:09am.

Refer to the interview with a second MA on 11/30/23 at 4:27pm.

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D 392	Continued From page 48 Refer to the telephone interview with a third MA on 11/30/23 at 5:09pm. Refer to the telephone interview with the Pharmacist on 11/30/23 at 11:17am. Refer to the telephone interview with the Administrator on 11/30/23 at 4:05pm. ___________________ Telephone interview with a MA on 11/30/23 at 11:09am revealed: -He administered medications to Resident #4 when he worked. -When he administered controlled medications, he documented both the scheduled and PRN medications administered on the MAR and the CSCS. Interview with a second MA on 11/30/23 at 4:27pm revealed: -Controlled medications were dispensed from the pharmacy in a single dose bubble card. -She documented on the CSCS and the MAR as soon as she popped the controlled medication from the bubble package. -She documented the administration of each controlled medication on the MAR and the CSCS. -The dose administered, remaining tablet count, the time, the date, and initials of the MA who administered the controlled medication were all documented on the CSCS. -Medications with half tablets as part of the order were already cut in half and packaged by the pharmacy, including controlled medications. -She was taught by another MA to count half a tablet as one dose for the CSCS when it was part of the order. -The MAs counted controlled medications between shifts at the shift change to verify the count.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001149	A. BUILDING: ______ B. WING ______	11/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 392	Continued From page 49 -The MAs used the MAR and the CSCS to verify the control counts; they did not sign off anywhere after they verified the count. -The controlled medication count had never been off that she remembered. Telephone interview with a third MA on 11/30/23 at 5:09pm revealed: -When she administered controlled medication, she signed off on both the MAR and the CSCS. -The MAs counted off at the beginning of every shift. -If a medication was returned to the pharmacy, she completed the pharmacy's return form and sent the medication with a copy of the return form to the pharmacy by the pharmacy staff when they delivered medications. -She would have to be at the facility to see what medication had been returned. Telephone interview with the Pharmacist on 11/30/23 at 11:17am revealed: -Controlled medication was not cycle filled and would need to be requested for refill. -For controlled medication, an order had to be signed each month by the PCP for the medication to be dispensed. -CSCS was a "count down sheet" so the staff at the facility could count down the medication so the facility would always have a perpetual count. -If a controlled medication was sent back, the facility should keep the CSCS and complete a return form so every dose could be tracked. -If the CSCS were not being used appropriately and the count did not match the medication on hand the concern would be controlled medication unaccounted for; there could be a diversion or have dangerous medication "just laying around." Telephone interview with the Administrator on	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 392	Continued From page 50 11/30/23 at 4:05pm revealed: -CSCS were to be kept in the MAR book. -She did not know if Resident #4 had a CSCS that was damaged. -When a controlled medication was administered, she expected the MAs to document on the MAR and the CSCS. -Two staff were required to count off on all controlled medication before the change of shift to verify the count was correct. -She had not completed an audit to make sure the controlled medication count was correct. -She was concerned the controlled medication had not been documented when the medication was administered because there were controlled medications not accounted for and the MAs were not following protocol. ______________________ The facility failed to ensure controlled substance count sheets were accurate for a resident receiving controlled drugs resulting in the facility not having an accurate reconciliation of 21 doses of Lacosamide 200mg, 13 doses of Clobazam 10mg, 68 tablets of Klonopin 0.5mg, and 53 tablets of Klonopin 1mg. The facility's failure to ensure a reconcilable record of controlled substances count sheets was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. ______________________ The facility submitted a Plan of Protection in accordance with G.S.131D-34 for this violation on 11/30/23. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JANUARY 14, 2024.	D 392		