STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011167	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAKING VISIONS COME TRUE ASSISTANT LIV	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 and the Alamance County Department of Social Services conducted an annual survey on 03/12/25-03/13/25.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure outside doors had a sounding device engaged that was audible throughout the facility when the door was opened which was accessible to 3 of 3 sampled residents (#1, #2, #3) who were identified as disoriented (#1, #2, #3). The findings are: Review of the facility's current license effective 01/01/25 revealed the facility was licensed for 12 beds.	D 067		

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D 067	Continued From page 1 Review of the facility's census on 03/12/25 revealed there were 12 residents residing in the assisted living facility. Observation of the facility on 03/12/25 at various times between 7:40am-6:00pm revealed: -The main entrance to the facility was unlocked and an alarm was not heard when the door was opened. -There was an exit door at the end of the hallway where the residents' rooms were located that was locked; no alarm was heard when the door was opened. -There was a third exit door that exited from the hallway that was not locked; no alarm was heard when the door was opened. Observation of the alarm control panel on 03/13/25 at 8:35am revealed: -The alarm panel was in the staff bedroom, which was behind/adjacent to the office/medication room. -The alarm panel announced when the entrance/exit door was opened. -When staff exited the office medication room, the door was closed. -The alarm panel could not be heard when the door was closed. Interview with 3 residents on 03/12/25 between 7:40am-6:00pm revealed: -Sometimes they heard an alarm on the door when it was opened, but not every day. -It had been "a while" since they had heard a door alarm. Interview with a medication aide (MA) on 03/12/25 at 1:40pm and 4:00pm revealed: -There were no residents who wandered. -There were no residents who were confused.	D 067		

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D 067	Continued From page 2 -The door alarms were only used at night or when everyone was leaving the facility. Interview with the Supervisor-in-Charge (SIC) on 03/13/25 at 8:22am revealed: -The facility had cameras to monitor the staff and residents. -There was not a monitor on-site to monitor the cameras. -The cameras were monitored by the Administrator. -If she was not in the office she would not know if a resident went outside. -The residents only entered and exited the facility through the main entrance door. Interview with the Administrator on 03/12/25 at 4:09pm revealed the door alarms were set between 9:00pm-9:30pm and deactivated at 6:30am. Interview with the Administrator on 03/13/25 at 12:19pm revealed: -She knew a door alarm was needed if a resident wandered or was at risk of wandering. -The facility had door alarms in place, but she did not know it could not be heard when staff were not in the office. 1. Review of Resident #3's current FL-2 dated 03/06/25 revealed: -Diagnoses included intellectual functioning disorder, schizoaffective disorder, hyperlipidemia, and vitamin D deficiency. -He was constantly confused. Review of Resident #3's Resident Register dated 01/30/25 revealed Resident #3 was forgetful and needed reminders.	D 067		

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Review of Resident #3's care plan dated 02/06/25 revealed:
-He was sometimes disoriented.
-He was forgetful and needed reminders.

Interview with Resident #3 on 03/13/25 at 7:36am revealed he liked to go outside; there were usually other residents outside too.

Interview with the Supervisor-in-Charge (SIC) on 03/13/25 at 8:22am revealed:
-Resident #3 was new to the facility.
-Resident #3 seemed like he was "with it".
-Resident #3 needed reminders.

Telephone interview with Resident #3's primary care provider (PCP) on 03/13/25 at 2:45pm revealed:
-She had only seen Resident #3 one time.
-She did not recall what his level of orientation was.
-She thought it would be helpful to have the door alarm on to know when Resident #3 went outside, just for his overall well-being, to be monitored.

2. Review of Resident #1's current FL-2 dated 08/22/24 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD), diastolic congestive heart failure (CHF), type 2 diabetes, and schizoaffective disorder.
-The recommended level of care was assisted living.
-He was intermittently disoriented.

Review of Resident #1's Resident Register dated 02/19/24 revealed Resident #1 was forgetful and needed reminders.

Review of Resident #2's care plan dated

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D 067	Continued From page 4 08/08/24/24 revealed he was oriented, and his memory was adequate. Interview with Resident #2 on 03/13/25 at 12:10pm revealed: -He liked to go outside. -Sometimes he was outside by himself, but usually there were other residents outside. -Sometimes the staff were outside. Interview with the Supervisor-in-Charge (SIC) on 03/13/25 at 8:22am revealed: -Resident #2 would ask the same thing when they had just had a conversation. -Resident #2 would ask things he knew the answer to. Attempted telephone interview with Resident #1's Primary Care Provider (PCP) on 03/13/25 at 9:46am was unsuccessful. 3. Review of Resident #2's current FL-2 dated 12/20/24 revealed: -Diagnoses included type 1 diabetes, chronic obstructive pulmonary disease (COPD), major depressive disorder, and alcohol abuse. -His recommended level of care was AL. -He was intermittently disorientated. Review of Resident #2's Resident Register revealed an admission date of 12/04/25. Review of Resident #2's care plan dated 12/20/24 revealed: -Resident #2 was sometimes disoriented. -Resident #2 was forgetful and needed reminders. Interview with Resident #2 on 03/13/25 at 7:45am revealed:	D 067		

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D 067	Continued From page 5 -He liked to go outside. -Sometimes there were other residents outside and sometimes it was "just" him. Interview with the Supervisor-in-Charge (SIC) on 03/13/25 at 8:22am revealed: -Resident #2 would ask the same thing when they had just had a conversation. -Resident #2 would ask things he knew the answer to. -Resident #2 had an intellectual disability. -Resident #2 needed reminders. Attempted telephone interview with Resident #2's Primary Care Provider (PCP) on 03/13/25 at 9:46am was unsuccessful.	D 067		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication	D 344		

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orders for 1 of 3 sampled residents (#2) for medications used to treat diabetes, chronic kidney disease (CKD), chronic obstructive pulmonary disease (COPD), an enlarged prostate, high blood pressure, constipation, nerve pain, an antipsychotic, a topical pain gel, supplements, and an antidepressant,

The findings are:

Review of Resident #2's current FL-2 dated 12/20/24 revealed:
-Diagnoses included type 1 diabetes, metabolic encephalopathy, underweight, muscle weakness, major depressive disorder, and chronic obstructive pulmonary disease (COPD).
-There was an order for Farxiga (used to treat diabetes) 10mg; no frequency was documented.
-There was an order for Wellbutrin (an antidepressant) XL to take 3 tablets daily; the dosage was not documented.
-There was an order for Thiamin (a supplement) 100mg; no frequency was documented.
-There was an order for Kerendia (used to treat chronic kidney disease (CKD)) 20mg; no frequency was documented.
There was an order for Lasix 20 mg (used to treat fluid build-up), but no frequency was documented.
-There was no order for Diclofenac gel (a topical gel used to treat pain), Senna plus (used to treat constipation), Vitamin B12 (a supplement), Gabapentin (used to treat nerve pain), Metoprolol (used to treat high blood pressure), and Tamsulosin (used to treat an enlarged prostate).

Review of Resident #2's January 2025 medication administration record (MAR) revealed:
-There was an entry for Farxiga 10 mg once daily with a scheduled administration time of 8:00am.

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-There was documentation Farxiga 10mg was administered daily from 01/01/25-01/31/25.
-There was an entry for Wellbutrin 150mg XL to take 1 tablet daily with a scheduled administration time of 8:00am.
-There was documentation Wellbutrin 150mg was administered daily from 01/01/25-01/31/25.
-There was an entry for Kerendia 20mg take 1 tablet daily with a scheduled administration time of 8:00am.
-There was documentation Kerendia 20mg was administered daily from 01/01/25-01/31/25.
-There was an entry for Diclofenac gel apply to bilateral feet twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Diclofenac gel was applied daily from 01/01/25-01/31/25.
-There was an entry for Senna plus take 2 tablets twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Senna plus was administered daily from 01/01/25-01/31/25.
-There was an entry for Vitamin B12 once daily with a scheduled administration time of 8:00am.
-There was documentation Vitamin B12 was administered daily from 01/01/25-01/31/25.
-There was an entry for Gabapentin 100mg at bedtime with a scheduled administration time of 8:00pm.
-There was documentation Gabapentin was administered daily from 01/01/25-01/31/25.
-There was an entry for Metoprolol 25mg, take ½ tablet (12.5mg) once daily with a scheduled administration time of 8:00am.
-There was documentation Metoprolol 12.5mg was administered daily from 01/01/25-01/31/25.
-There was an entry for Tamsulosin 0.4mg take 1 tablet daily with a scheduled administration time of 8:00am.
-There was documentation Tamsulosin 0.4mg

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administered daily from 01/01/25-01/31/25.
-There was no entry for Thiamin 100mg or Lasix 20mg.

Review of Resident #2's February 2025 MAR revealed:
-There was an entry for Farxiga 10 mg once daily with a scheduled administration time of 8:00am.
-There was documentation Farxiga 10mg was administered daily from 02/01/25-02/28/25.
-There was an entry for Wellbutrin 150mg XL to take 1 tablet daily with a scheduled administration time of 8:00am.
-There was documentation Wellbutrin 150mg was administered daily from 02/01/25-02/28/25.
-There was an entry for Kerendia 20mg take 1 tablet daily with a scheduled administration time of 8:00am.
-There was documentation Kerendia 20mg was administered daily from 02/01/25-02/28/25.
-There was an entry for Diclofenac gel apply to bilateral feet twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Diclofenac gel was applied daily from 02/01/25-02/28/25.
-There was an entry for Senna plus take 2 tablets twice daily with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation Senna plus was administered daily from 02/01/25-02/28/25.
-There was an entry for Vitamin B12 once daily with a scheduled administration time of 8:00am.
-There was documentation Vitamin B12 was administered daily from 02/01/25-02/28/25.

-There was an entry for Gabapentin 100mg at bedtime with a scheduled administration time of 8:00pm.
-There was documentation Gabapentin was administered daily from 02/01/25-02/28/25.

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D 344	Continued From page 9 -There was an entry for Metoprolol 25mg, take ½ tablet (12.5mg) once daily with a scheduled administration time of 8:00am. -There was documentation Metoprolol 12.5mg was administered daily from 02/01/25-02/28/25. -There was an entry for Tamsulosin 0.4mg take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation Tamsulosin 0.4mg administered daily from 02/01/25-02/28/25. -There was no entry for Thiamin 100mg or Lasix 20mg. Review of Resident #2's March 2025 MAR from 03/10/25-03/12/25 revealed: -There was an entry for Farxiga 10 mg once daily with a scheduled administration time of 8:00am. -There was documentation Farxiga 10mg was administered daily from 03/10/25-03/12/25. -There was an entry for Wellbutrin 150mg XL to take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation Wellbutrin 150mg was administered daily from 03/10/25-03/12/25. -There was an entry for Kerendia 20mg take 1 tablet daily with a scheduled administration time of 8:00am. -There was documentation Kerendia 20mg was administered daily from 03/10/25-03/12/25. -There was an entry for Diclofenac gel apply to bilateral feet twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Diclofenac gel was applied daily at 8:00am at 03/10/25-03/12/25 and at 8:00pm on 03/10/25-03/11/25. -There was an entry for Senna plus take 2 tablets twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation Senna plus was administered daily from at 8:00am at	D 344		

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03/10/25-03/12/25 and at 8:00pm on 03/10/25-03/11/25.
-There was an entry for Vitamin B12 once daily with a scheduled administration time of 8:00am.
-There was documentation Vitamin B12 was administered daily from 03/10/25-03/12/25.
-There was an entry for Gabapentin 100mg at bedtime with a scheduled administration time of 8:00pm.
-There was documentation Gabapentin was administered daily from 03/10/25-03/11/25.
-There was an entry for Metoprolol 25mg, take ½ tablet (12.5mg) once daily with a scheduled administration time of 8:00am.
-There was documentation Metoprolol 12.5mg was administered daily from 03/10/25-03/12/25.
-There was an entry for Tamsulosin 0.4mg take 1 tablet daily with a scheduled administration time of 8:00am.
-There was documentation Tamsulosin 0.4mg administered daily from 03/10/25-03/12/25.
-There was no entry for Thiamin 100mg or Lasix 20mg.

Observation of Resident #2's medications on hand on 03/12/25 at 2:21pm revealed:
-There was a multi-dose package labeled as 8:00am that contained Farxiga 10mg, Kerendia 20mg, Metoprolol 25mg (1/2 tablet), 2 tablets of Senna plus, and Vitamin B-12.
-There was a multi-dose package labeled as 8:00pm that contained 2 tablets of Senna plus.
-There was a punch card dispensed on 02/25/25 for Wellbutrin XL 150mg with 11 of 30 tablets remaining on the card.
-There was a punch card dispensed on 02/25/25 for Tamsulosin 0.4mg with 15 of 30 tablets remaining on the card.
-There was a punch card dispensed on 02/25/25 for Gabapentin 100mg with 13 of 30 tablets

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remaining on the card.
-There was a tube of Diclofenac gel dispensed on 12/04/24; it was 50% full.
-There was a second tube of Diclofenac gel dispensed on 02/03/25; it was 50% full.

Telephone interview with a representative from the facility's contracted pharmacy on 03/12/25 at 12:26pm and 4:26pm revealed:
-Resident #2's order for Farxiga 10mg was received on 12/04/24.
-If the FL-2 dated 12/20/24 was received the Farxiga order would have been clarified for frequency.
-Resident #2's order for Wellbutrin 150mg XL was received on 12/04/24 and 02/21/25.
-If the FL-2 dated 12/20/24 was received the dosage for Wellbutrin would have been clarified.
-There was no order on file for Thiamine for Resident #2.
-If the FL-2 dated 12/20/24 was received the frequency for Thiamine would have been clarified and the medication would have been dispensed.
-Resident #2's order for Kerendia was received on 12/04/24.
-If the FL-2 dated 12/20/24 was received the Kerendia order would have been clarified for frequency.
-There was no order on file for Lasix for Resident #2.
-If the FL-2 dated 12/20/24 was received the frequency for Lasix would have been clarified and the medication would have been dispensed.
-Resident #2's order for Gabapentin 100mg once daily was received on 12/04/24 and 02/21/25.
-If the FL-2 dated 12/20/24 was received and Gabapentin was not listed the medication would have been discontinued.
-Resident #2's order for Metoprolol 25mg, ½ tablet once daily was received on 12/04/24 and

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02/26/25.
-If the FL-2 dated 12/20/24 was received and Metoprolol was not listed the medication would have been discontinued.
-Resident #2's order for Tamsulosin 0.4mg once daily was received on 12/04/24 and 02/21/25.
-If the FL-2 dated 12/20/24 was received and Tamsulosin was not listed the medication would have been discontinued.
-Resident #2's order for Vitamin B-12 once daily was received on 12/04/24 and 02/26/25.
-If the FL-2 dated 12/20/24 was received and Vitamin B-12 was not listed the medication would have been discontinued.
-Resident #2's order for Gabapentin 100mg once daily was received on 12/04/24, 02/21/25, and 02/26/25.
-If the FL-2 dated 12/20/24 was received and Senna plus was not listed, the medication would have been discontinued.
-Resident #2's order for Diclofenac gel apply 2 grams twice daily was received on 12/04/24 and 02/21/25.
-If the FL-2 dated 12/20/24 was received and the Diclofenac gel not listed, the medication would have been discontinued.
-There was no documentation a staff member had called from the facility to clarify Resident #2's medications.

Telephone interview with Resident #2's primary care provider's (PCP) medical assistant on 03/12/25 at 4:42pm revealed:
-Resident #2's current FL-2 on file was dated 12/20/24.
-She thought the FL-2 had been filled in at the PCP's office.
-The first time the PCP wrote an order for Resident #2's Gabapentin, Senna plus, Vitamin B-12, Tamsulosin, and Metoprolol was on

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D 344	Continued From page 13 02/21/25. -Resident #2's Wellbutrin was supposed to be 2 tablets of Wellbutrin 150 XL once daily was an active order on 10/03/24 and 12/20/24. -The PCP prescribed 1 tablet of Wellbutrin 150 XL once daily on 02/21/25. -She did not know why Thiamine and Lasix were listed on Resident #2's FL-2 as she did not see an order for it. -She would have expected the facility staff to have clarified the orders. Telephone interview with a representative from the facility's contracted pharmacy on 03/13/25 at 10:02am revealed Resident #2's order for Farxiga 10mg, Wellbutrin 150mg XL one tablet, Kerendia 20mg, Gabapentin 100mg, Metoprolol 25mg ½ tablet, Tamsulosin 0.4mg, Vitamin B-12, Gabapentin 100mg, Senna plus, and Diclofenac gel were all received on 12/04/24 from a physician at the skilled nursing facility (SNF) Resident #2 was being discharged from. Interview with Resident #2 on 03/12/25 at 3:47pm revealed: -He did not know the names of "all" the medications he took because he took "a bunch" of medications. -He used Diclofenac gel on his legs and feet at bedtime. -He took whatever medications the medication aide (MA) gave him. Interview with the MA on 03/12/25 at 4:00pm revealed: -When new medications were delivered each month, the MA working should compare the FL-2, MAR, and medications delivered to ensure they matched. -If something did not match the MA should	D 344		

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contact the Administrator.
-He recalled in February 2025, Resident #2's cycle medication multi-dose package did not contain all the medications the resident usually took.
-New orders were obtained and the pharmacy sent individual bubble packs of those medications.

Interview with the Facility Manager on 03/12/25 at 6:04pm revealed:
-The Administrator prepared FL-2s and he dropped them off at the PCPs office.
-Whoever was working when the FL-2 was returned was responsible for comparing the FL-2, the MAR, and the medications on hand.
-If there were any discrepancies, the staff member should contact the pharmacy.
-If it did not match, he expected the staff member to get it clarified.

Interview with the Supervisor-in-Charge (SIC) on 03/12/25 at 6:10pm revealed:
-The facility's Registered Nurse (RN) was responsible for looking at the FL-2 to ensure it was correct, by matching the MAR and the medications on hand.
-If the FL-2 did not match she should call the pharmacy to verify and get a new order.
-If an order was clarified the staff documented it in the communication log.
-She reviewed the communication log and did not see any clarification for Resident #2's medications.

Interview with the RN on 03/12/25 at 6:55pm revealed:
-When a new FL-2 came in, she compared the FL-2 to the MARs and the medications on hand.
-If anything did not match, she would call the

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D 344	Continued From page 15 pharmacy and the PCP to get clarification. Interview with the Administrator on 03/13/25 at 12:19pm revealed: -When medications were delivered the staff member working would compare the medications to the order and the MAR and if there were any discrepancies, contact the pharmacy and the PCP and document the telephone call. -The medications and MARs were also reviewed by the RN.	D 344		
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, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 3 sampled residents (#1, #2) including two medications used to prevent bronchospasm (#1) and insulin used to control blood sugars (#2). The findings are: 1. Review of Resident #2's current FL-2 dated	D 358		

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12/20/24 revealed:
-Diagnoses included type 1 diabetes, underweight, and muscle weakness.
-There was an order for Humalog (rapid-acting insulin used to lower blood sugar levels) 100/milliliter (ml) insulin sliding scale (ISS); there was no other information.

Review of Resident #2's admitting FL-2 dated 11/29/24 revealed an order for Humalog 100 unit/ml; there was no other information.

Reveal of Resident #2's order summary report dated 12/04/24 revealed:
-There was an order for Humalog 100units/ml inject as per sliding scale (SS), if the blood sugar (BS) reading was 70-120=0 insulin, 121-150=2 units, 151-200=3 units, 201-250=5 units, 251-300=8 units, 301-350=11 units, 351-400=15 units and to notify the primary care provider (PCP) if over 401.
-The area for the PCP to approve the order for Resident #2 was not signed or dated.

Review of Resident #2's physician's order dated 12/10/24 revealed an order for Humalog inject 6 units at breakfast and supper and 7 units at lunch. If BS was greater than 300 administer an additional 2 units and if less than 100 cut the dose in half.

Review of Resident #2's pharmacy review dated 03/05/25 revealed the Humalog directions needed to be verified, some doses did not seem correct.

Review of Resident #2's January 2025 medication administration record (MAR) revealed:
-There was an entry for Humalog 100units/ml inject three times daily per SS with a scheduled

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administration time of 8:00am, 12:00pm, and 5:00pm.
-The medication aide (MA) initialed Humalog was administered daily from 01/01/25-01/31/25.
-There was a second entry for Humalog 100 unit/ml, inject 6 units at breakfast and supper and 7 units at lunch. If the BS reading was greater than 300 administer an additional 2 units and if the BS reading was less than 100 give ½ the insulin dose scheduled at 8:00am, 12:00pm, and 5:00pm.
-The MA initialed Humalog was administered three times daily from 01/01/25-01/31/25.

Review of Resident #2's January 2025 BS log from 01/06/25-01/31/25 revealed:
-The BS log had a column for the day of the month, the BS results, the units administered, and the MA initials.
-At 8:00am, Resident #2's BS readings were documented ranging from 88-347.
-There were 26 times Resident #2 was not administered Humalog as ordered with examples as follows:
-There were 5 times Resident #2 was not administered any Humalog when his BS readings were greater than 100 and he should have been administered 6 units.
-There were 5 times Resident #2 was administered 2 units of Humalog and he should have been administered 6 units.
-There were 2 times Resident #2 was administered 8 units of Humalog; He should have been administered 6 units.
-At 12:00pm, Resident #2's BS was documented ranging from 70-336.
-There were 26 times Resident #2 was not administered Humalog as ordered with examples as follows:
-There were 3 times Resident #2 was not

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D 358	Continued From page 18 administered any Humalog when his BS readings were greater than 100 and he should have been administered 6 units. -There were 8 times Resident #2 was administered 2 units of Humalog and he should have been administered 6 units. -There were 2 times Resident #2 was administered 11 units of Humalog; He should have been administered 8 units. -At 5:00pm, Resident #2's BS was documented ranging from 68-377. -There were 26 times Resident #2 was not administered Humalog as ordered with examples as follows: -There were 7 times Resident #2 was not administered any Humalog when his BS readings were greater than 100, and he should have been administered 6 units. -There were 4 times Resident #2 was administered 2 units of Humalog and he should have been administered 6 units. -There were 2 times Resident #2 was administered 11 units of Humalog and he should have been administered 8 units. -There were 2 times Resident #2 was administered 15 units of Humalog and he should have been administered 8 units. Telephone interview with a representative from the facility's contracted pharmacy on 03/12/25 at 12:26pm and 4:26pm revealed: -Resident #2's current order dated 12/10/24 for Humalog, was to inject 6 units at breakfast and dinner and 7 units at lunch; if the resident's BS reading was greater than 300 administer an additional 2 units and if the BS reading was less than 100 administer ½ of the scheduled insulin dose. -There was no documentation Resident #2's FL-2 dated 12/20/24 was received at the pharmacy.	D 358		

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-If the FL-2 dated 12/20/24 had been received, the order for Resident #2's Humalog would have been clarified.
-Two pens of Humalog were dispensed on 12/10/24, 01/06/25 and 03/06/25.
-Each pen dispensed was 300 units and would last approximately 16 days if the resident received 19 units per day.

Telephone interview with a representative from the facility's contracted pharmacy on 03/13/25 at 10:02am revealed:
-On 12/04/24, an order was received for Resident #2's Humalog SS; the order was from a physician at a skilled nursing facility (SNF).
-On 12/10/24, an order was received for Resident #2's Humalog with orders for a set amount of insulin to be administered, 6 units at breakfast and supper and 7 units at lunch; the order was from Resident #2's PCP.
-The order received on 12/10/24 was to replace the Humalog SS order dated 12/04/24.
-On 01/06/25, clarification was received on the duplicate entry and the Humalog SS had been discontinued and was removed from the MAR.

Telephone interview with the facility's consulting Pharmacist on 03/13/25 at 10:17am revealed:
-He did a pharmacy review on 03/05/25 but he did not have a copy of the documentation he provided to the facility.
-He recalled something about Resident #2's Humalog and some doses did not coincide with the directions.
-He thought the order had changed from what was being documented as administered.
-He mentioned it to a [named] nurse who was at the facility.
-When he wrote the recommendation, he expected a staff member to contact the resident's

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D 358	Continued From page 20 PCP to get the order clarified and to get a new order if one was needed. Review of Resident #2's February 2025 MAR revealed: -There was an entry for Humalog 100 unit/ml, inject 6 units at breakfast and supper and 7 units at lunch. If the BS reading was greater than 300 administer an additional 2 units and if the BS reading was less than 100 give ½ the insulin dose scheduled at 8:00am, 12:00pm, and 5:00pm. -The MA initialed Humalog was administered three times daily from 02/01/25-02/28/25. Review of Resident #2's February 2025 BS log revealed: -At 8:00am, Resident #2's BS was documented ranging from 72-263. -There were 28 times Resident #2 was not administered Humalog as ordered with examples as follows: -There were 6 times Resident #2 was not administered any Humalog when his BS readings were greater than 100 and he should have been administered 6 units. -There were 8 times Resident #2 was administered 2 units of Humalog and he should have been administered 6 units. -There were 7 times Resident #2 was administered 3 units of Humalog and he should have been administered 6 units. -At 12:00pm, Resident #2's BS were documented ranging from 69-332. -There were 28 times Resident #2 was not administered Humalog as ordered with examples as follows: -There were 5 times Resident #2 was not administered any Humalog when his BS readings were greater than 10 and he should have been administered 6 units.	D 358		

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-There were 6 times Resident #2 was administered 2 units of Humalog and he should have been administered 6 units.
-There were 5 times Resident #2 was administered 3 units of Humalog and he should have been administered 6 units.
At 5:00pm, Resident #2's BS was documented ranging from 112-380.
-There were 28 times Resident #2 was not administered Humalog as ordered with examples as follows:
-There were 2 times Resident #2 was not administered any Humalog when his BS readings were greater than 100 and he should have been administered 6 units.
-There was 1 time Resident #2 was administered 2 units of Humalog; he should have been administered 6 units.
-There were 9 times Resident #2 was administered 11 units of Humalog and he should have been administered 8 units.
-There was 1 time Resident #2 was administered 15 units of Humalog and he should have been administered 8 units.

Review of Resident #2's March 2025 MAR from 03/01/25-03/12/25 revealed:
-There was an entry for Humalog 100 unit/ml, inject 6 units at breakfast and supper and 7 units at lunch. If the BS reading was greater than 300 administer an additional 2 units and if the BS reading was less than 100 give ½ the insulin dose scheduled at 8:00am, 12:00pm, and 5:00pm.
-The MA initialed Humalog was administered three times daily from 03/01/25-03/12/25.

Review of Resident #2's March 2025 BS log from 03/01/25-03/12/25 at 8:00am revealed:
-At 8:00am, Resident #2's BS was documented ranging from 93-364.

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D 358	Continued From page 22 -There were 12 times Resident #2 was not administered Humalog as ordered with examples as follows: -There were 3 times Resident #2 was not administered any Humalog when his BS readings were greater than 100 and he should have been administered 6 units. -There were 5 times Resident #2 was administered 3 units of Humalog and he should have been administered 6 units. -At 12:00pm, Resident #2's BS was documented ranging from 88-276. -There were 11 times Resident #2 was not administered Humalog as ordered with examples as follows: -There were 2 times Resident #2 was not administered any Humalog when his BS readings were greater than 100 and he should have been administered 6 units. -There were 2 times Resident #2 was administered 2 units of Humalog and he should have been administered 6 units. -At 5:00pm, Resident #2's BS were documented ranging from 104-438. -There were 11 times Resident #2 was not administered Humalog as ordered with examples as follows: -There were 2 times Resident #2 was not administered any Humalog when his BS readings were greater than 100, and he should have been administered 6 units. -There were 2 times Resident #2 was administered 11 units of Humalog; He should have been administered 8 units. -There were 2 times Resident #2 was administered 15 units of Humalog; He should have been administered 8 units. Observation of Resident #2's medications on hand on 03/12/25 at 11:43am and 2:51pm	D 358		

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D 358	Continued From page 23 revealed: -There were 3 individually packaged Humalog pens. -One Humalog pen was labeled as 2 of 2 and was dispensed on 01/06/25, -A second pen was labeled as 1 of 2 and was dispensed on 03/06/25. -A third pen was labeled as 2 of 2 and was dispensed on 03/06/25. -Each label had the directions to administer 6 units at breakfast and supper and 7 units at lunch. If blood sugar was greater than 300 administer an additional 2 units and if less than 100 cut the insulin dose in half. -The pen dated 01/06/25 had approximately 20 units of Humalog insulin remaining in the pen. -The pens dispensed on 03/06/25 had not been used. Interview with Resident #2 on 03/12/25 at 3:47pm and 6:43pm revealed: -He had a Dexcom device to monitor his blood sugar levels. (A Dexcom unit monitors BS levels in real-time). -He showed his BS to the MA four times a day. -The amount of Humalog he took depended on the results of his BS. -He had been on SS insulin since he was admitted to the facility. Interview with a MA on 03/12/25 at 4:00pm revealed: -Resident #2's Humalog was administered on a SS depending on his BS readings. -Today, 03/12/25, Resident #2 was administered 2 units of Humalog based on a BS reading of 140. -If Resident #2's BS was a "certain reading" the resident would be administered Humalog. -He had never administered Resident #2's	D 358		

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Humalog like the entry on the March 2025 eMAR.
-Resident #2's Humalog was administered based on a SS and had been that way since he was admitted to the facility.
-He had a note posted in the medication office that had the SS directions on it.

Review of a handwritten note provided by the MA on 03/12/25 at 4:11pm revealed:
-The note was on a 3-inch by 3-inch piece of bright pink paper.
-The note had Resident #2's name written on it.
-The note was not dated.
-The following information was written BS of 70-120=0, 121-150=2, 151-200=3, 2021-250=5, 251-300=8, 301-350=11, and 351-400=15.

Telephone interview with a second MA on 03/12/25 at 5:50pm revealed:
-Resident #2 showed him his BS reading and he would write it down.
-He administered Resident #2's Humalog if his BS reading was more than 150.
-He used the SS in the medication office on a pink piece of paper.
-He looked at Resident #2's MAR when he administered the insulin.
-Resident #2's MAR had a SS insulin listed.
-He was not going to answer any more questions because he could not see the MAR to discuss.

Review of Resident #2's laboratory values dated 12/26/24 revealed a hemoglobin A1C (HbA1c) value of 8.0. The hemoglobin A1c test measures the average level of blood sugar over the past 2 to 3 months. (According to the American Diabetic Association a HbA1c value less than 7.0 was a goal for diabetic residents with the normal range for HbA1c being 4 to 5.9).

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MAKING VISIONS COME TRUE ASSISTANT LIV	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 358	Continued From page 25 Telephone interview with Resident #2's PCP's medical assistant on 03/12/25 at 4:42pm revealed Resident #2's current order for Humalog was to administer 6 units at breakfast and supper and 7 units at lunch. If the blood sugar was greater than 300 administer 2 additional units and if less than 100 cut the dosage in half. Telephone interview with Resident #2's PCP on 03/12/25 at 5:02pm revealed: -If Resident #2's Humalog was not administered as ordered, it could be affecting his "day to day BS." -She was concerned Resident #2's Humalog was not administered correctly because the resident was a type 1 diabetic. -Resident #2 had so many issues with being hyperglycemic and hypoglycemic in the past. -Resident #2 got a Dexcom and a referral was made on 12/20/24 for him to see an Endocrinologist to possibly get an insulin pump. -Resident #2 was working at a local fast-food restaurant but until his BS was straightened out, working was not in his best interest, so she had not released him to return to work. -Resident #2's Humalog was a scheduled dose. -Resident #2's Humalog was not supposed to be a SS, "I do not know where that came from." -Resident #2's BS readings may be more erratic if his Humalog was not administered as ordered. -Because Resident #2 was a type 1 diabetic, his pancreas did not make any insulin at all, so he should be getting dosed with a set amount of insulin. -If Resident #2's BS reading was high, and he was not administered Humalog his BS reading was going to continue to increase. -If Resident #2's BS was not well controlled the resident would have negative outcomes. -Negative outcomes of elevated BS readings	D 358		

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included eye disease, cardiovascular disease, kidney disease, and peripheral disease.
-Over time the body and organs would be damaged.
-If Resident #2 had been administered his Humalog as ordered, "it would have made a difference."
-Resident #2's last HbA1c (was 8 on 12/26/24, ideally would like the HbA1c to be in the "7ish range."

Interview with the House Manager on 03/12/25 at 6:04pm revealed:
-The Administrator prepared FL-2s and he dropped them off at the PCP's office.
-Whoever was working when the FL-2 was returned was responsible for comparing the FL-2, the eMAR, and the medications on hand.
-If there were any discrepancies, the staff member should contact the pharmacy.
-If it did not match, he expected the staff member to get it clarified.
-The Supervisor-in-Charge (SIC) was a second set of eyes for the insulin.
-The Registered Nurse (RN) oversaw the medications.

Interview with the SIC on 03/12/25 at 6:10pm revealed:
-The facility's RN was responsible for looking at the FL-2 to ensure it was correct, by matching the MAR and the medications on hand.
-If the FL-2 did not match she should call the pharmacy to verify and get a new order.
-If an order was clarified the staff documented it in the communication log.
-She reviewed the communication log and did not see any clarification for Resident #2's medications.
-Resident #2's Humalog was administered

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depending on his BS readings.
-For example, if Resident #2's BS reading was 150, he would be administered 5 units.
-She did not know Resident #2 had an order for scheduled Humalog.

Interview with the RN on 03/12/25 at 6:55pm revealed:
-When a new FL-2 came in, she compared the FL-2 to the MARs and the medications on hand.
-If anything did not match, she would call the pharmacy and the PCP to get clarification.
-Resident #2's SS parameters were not on the FL-2 dated 12/20/24 but they were listed on Resident #2's December 2024 MAR.
-She expected the MAs to follow the MAR.
-It was very concerning Resident #2's Humalog had not been administered as ordered, because he could have had problems with his BS readings, like a diabetic coma.
-It was very serious that the medication had not been administered as ordered.

Observation of the hallway/living room on 03/13/25 at 8:20am revealed:
-Staff members were heard telling Resident #2 to sit down.
-A MA stated he had given Resident #2 two containers of orange juice.
-Resident #2 was sitting in the living room.
-He had 2 empty containers of orange juice sitting on the table by his chair.
-His Dexcom showed a BS reading of 56.
-At 8:30am, the House Manager left the facility with Resident #2 to have him evaluated.

Review of Resident #2's March 2025 BS log for 03/13/25 at 8:00am revealed Resident #2's BS reading was documented as 364 and 15 units of Humalog were administered.

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D 358	Continued From page 28 Interview with the SIC on 03/13/25 at 11:32am revealed: -She thought the MA used the SS for Resident #2's Humalog today, 03/13/25, because they were going to get clarification on the order. -She told the MA what the issues were with Resident #2's Humalog order, but she did not tell him which order to use for administering his Humalog. Interview with the SIC and the RN on 03/13/25 at 11:35am revealed they expected the MA to have reviewed Resident #2's MAR and the medication on hand and administered Resident #2 6 units of Humalog as ordered. Telephone interview with the MA on 03/13/25 at 11:51am revealed: -He administered Resident #2's SS today, 03/13/25, because he had not been told the order was clarified. -The SIC did talk to him on 03/12/25, but he did not remember everything she told him. -Resident #2's order for the SS was "fairly recent". -Resident #2's BS reading was 61 before he left the facility at 8:30am. Interview with Resident #2 on 03/13/25 at 12:10pm revealed: -When he woke up today, 03/13/25, around 6:00am, his Dexcom showed his blood sugar as 364. -The MA gave him 15 units of Humalog. -He ate breakfast around 6:30am. -He started feeling weak, he did not recall the time, and his Dexcom showed his BS reading as 42. -He drank 2 orange juices, and his blood sugar	D 358		

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was still low.
-He then stated he had 2 apple juices, not orange juices.
-He felt "really bad" when his blood sugar was low, he would start sweating and his body would feel like bee stings all over, "it was hard to explain".
-Today, 03/13/25, he started sweating and his body felt like bee stings all over, so the House Manager took him to see his PCP.
-His BS was still low.
-He had eaten a hamburger for lunch.
-He was going to lie down and rest for a little while to see if he felt better.
-He could not "think good" when his BS was low.

Observation of Resident #2's Dexcom device on 03/13/25 at 12:08pm revealed the display showed a reading of 64.

Interview with the Administrator on 03/13/25 at 12:19pm revealed:
-She expected the MA to follow the PCP's orders.
-When the MA administered medication, she expected the MA to make sure the medication label matched the MAR and if it did not, the MA should have verified which was correct.
-When medications were delivered the staff member working would compare the medications to the order and the MAR and if there were any discrepancies, contact the pharmacy and the PCP and document the telephone call.
-The medications and MARs were also reviewed by the RN.
-The RN was responsible for reviewing the Pharmacist recommendations.
-She expected the SIC to have relayed the conversation about Resident #2's Humalog order with the MA or to administer the medication.
-She was concerned the orders were not being

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followed which could pose a risk to the residents.
-The PCP wrote an order today, 03/13/25, to discontinue Resident #2's SS order.
-Resident #2's SS order was not discontinued until today, 03/13/25.

2. Review of Resident #1's current FL-2 dated 08/22/24 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD), diastolic congestive heart failure (CHF), type 2 diabetes, and schizoaffective disorder.
-He was intermittently disoriented.

a. Review of Resident #1's current FL-2 dated 08/22/24 revealed an order for Perforomist (a long-acting bronchodilator used to relax muscles in the airways to improve breathing) 20mcg/ml vial twice daily.

Review of Resident #1's January medication administration record (MAR) revealed:
-There was an entry for Perforomist to use 1 vial twice daily with a scheduled administration time of 8:00am and 9:00pm.
-Perforomist was documented as administered twice daily from 01/01/25-01/31/25 at 8:00am and 9:00pm.

Review of Resident #1's February MAR revealed:
-There was an entry for Perforomist to use 1 vial twice daily with a scheduled administration time of 8:00am and 9:00pm.
-Perforomist was documented as administered twice daily from 02/01/25-02/28/25 at 8:00am and 9:00pm.

Review of Resident #1's March MAR from 03/01/25-03/12/25 revealed:
-There was an entry for Perforomist to use 1 vial

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twice daily with a scheduled administration time of 8:00am and 9:00pm.
-Perforomist was documented as administered twice daily from 03/01/25-03/12/25 at 8:00am and 9:00pm.

Observation of Resident #1's medications on hand on 03/12/25 at 11:38am revealed:
-There was a box of 60 Perforomist individually packaged vials dispensed on 12/10/24 with the directions to inhale one vial twice daily; there were 46 vials remaining in the box.
-There was a second box of 60 Perforomist individually packaged vials dispensed on 01/20/25 with the directions to inhale one vial twice daily; there were 60 vials remaining in the box.
-There was a plastic package that contained 30 Perforomist individually packaged vials dispensed on 03/05/25 with the directions to inhale one vial twice daily; there were 30 vials remaining in the box.

Telephone interview with a Pharmacist at Resident #1's respiratory supply company on 03/12/25 at 12:56pm revealed:
-Resident #1's current order dated 03/13/24 was to use Perforomist twice daily.
-Resident #1 had 60 vials of Perforomist dispensed on 12/10/24 and 01/20/25.
-On 03/05/25, a call was received, the caller's name was not documented, but they only requested 30 vials be sent, because the resident was only doing one nebulizer treatment per day, so the pharmacy dispensed 30 vials.

b. Review of Resident #1's current FL-2 dated 08/22/24 revealed an order for Ipratropium/ Albuterol combination solution, use one vial twice daily.

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D 358	Continued From page 32 Review of Resident #1's January MAR revealed: -There was an entry for Ipratropium/ Albuterol use 1 vial twice daily with a scheduled administration time of 8:00am and 9:00pm. -Ipratropium/ Albuterol was documented as administered twice daily from 01/01/25-01/31/25 at 8:00am and 9:00pm. Review of Resident #1's February MAR revealed: -There was an entry for Ipratropium/ Albuterol use 1 vial twice daily with a scheduled administration time of 8:00am and 9:00pm. -Ipratropium/ Albuterol was documented as administered twice daily from 02/01/25-02/28/25 at 8:00am and 9:00pm. Review of Resident #1's March MAR from 03/01/25-03/12/25 revealed: -There was an entry for Ipratropium/ Albuterol use 1 vial twice daily with a scheduled administration time of 8:00am and 9:00pm. -Ipratropium/ Albuterol was documented as administered twice daily from 03/01/25-03/12/25 at 8:00am and 9:00pm. Observation of Resident #1's medications on hand on 03/12/25 at 11:38am revealed: -There was a box of 30 Ipratropium/ Albuterol individually packaged vials dispensed on 12/10/24 with the directions to inhale one vial twice daily and as needed (PRN) (max 30/month); there were 30 vials remaining in the box. -There was a second box of 30 Ipratropium/ Albuterol individually packaged vials dispensed on 01/20/25 with directions to inhale one vial twice daily and PRN; there were 30 vials remaining in the box. -There was a third box of 30 Ipratropium/	D 358		

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D 358	Continued From page 33 Albuterol individually packaged vials dispensed on 03/05/25 with the directions to inhale one vial twice daily and PRN; there were 30 vials remaining in the box. Telephone interview with a representative from the facility's contracted pharmacy on 03/12/25 at 12:26pm revealed: -Resident #1's Ipratropium/ Albuterol was dispensed only once, on 03/12/24 for 60 vials. -The order for Ipratropium/ Albuterol was written on 12/28/23 for 2 vials per day. Telephone interview with a Pharmacist at Resident #1's respiratory supply company on 03/12/25 at 12:56pm revealed Resident #1's Ipratropium/ Albuterol was dispensed on 12/10/24, 01/20/25, and 03/05/25; each dispensing was for 30 vials. Telephone interview with the Pharmacist at Resident #1's respiratory supply company on 03/13/25 at 9:51am revealed: -Resident #1's current order for the Ipratropium/ Albuterol was dated 03/13/24 with the directions to inhale one vial four times daily and as needed. -Because Resident #1's Perforomist also contained albuterol, the insurance company would only approve 30 vials to be dispensed monthly. _____ Interview with a MA on 03/12/25 at 3:53pm revealed: -Resident #1 was administered breathing treatments PRN. -Resident #1 usually told him when he needed a breathing treatment. -He could not say which breathing treatment medication he used because the pharmacy sent different ones.	D 358		

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D 358	Continued From page 34 -Resident #1 had not had a breathing treatment "in a while", a couple of weeks. -Resident #1 had not asked for a breathing treatment. Telephone interview with a MA on 03/12/25 at 5:50pm revealed: -Resident #1 was administered medication in his breathing machine whenever the resident needed it. -Resident #1's breathing treatment medication order was PRN. -Resident #1's breathing treatment was administered twice daily. -He would not answer any further questions to clarify the two statements. Interview with the facility's Registered Nurse (RN) on 03/12/25 at 6:55pm revealed she was concerned Resident #1 could experience respiratory and pulmonary problems if the resident's nebulizer treatments were not administered as ordered, especially since the resident still smoked. Telephone interview with a Pharmacist at Resident #1's respiratory supply company on 03/12/25 at 12:56pm revealed: -Resident #1's nebulizer treatments were only dispensed when the medication was requested to be refilled by the facility staff; it was not cycle filled. -If Resident #1's nebulizer treatments were not administered as ordered the resident could experience shortness of breath, wheezing, and bronchi restrictions. Observation of Resident #1 on 03/12/25 at 3:41pm revealed: -The resident was lying on his bed.	D 358		

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D 358	Continued From page 35 -A high-pitched whistling noise (wheezing) could be heard when he breathed in and out. Interview with Resident #1 on 03/12/25 at 3:41pm revealed: -His breathing "always sounded like this". -He used his breathing machine (nebulizer) twice a day. Interview with Resident #1 on 03/13/25 at 7:45am revealed: -He was told last night, 03/12/25, that he had to do his breathing treatment 4 times daily. -He did not think he needed breathing treatments 4 times daily. -Sometimes he did get short of breath, but when he was "like this" he asked for a breathing treatment. -He did not do breathing treatments every day. -His Primary Care Provider (PCP) told him he did not need to do breathing treatments unless he needed it, and he did not need it every day. -Some days he did not need a breathing treatment "at all". -Some days he might need breathing treatment once a day, but not very often. Interview with the Administrator on 03/13/25 at 12:19pm revealed: -Resident #1 refused his breathing treatments for 6 months straight which was why he had so many vials on hand. -Resident #1's PCP told him in October 2024 that he was doing well, and he refused nebulizer treatments for the entire month of October 2024. -The PCP was contacted to get a discontinue order in October 2024, but it was not received. -Resident #1 smoked 25 cigarettes daily. -Not following orders as written posed a risk to the resident.	D 358		

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D 358	Continued From page 36 Attempted telephone interview with Resident #1's PCP on 03/13/25 at 9:46am was unsuccessful. _____ The facility failed to administer medications as ordered to a resident who was a type 1 diabetic and had an order for insulin to be administered. The resident had an order for a scheduled amount of Humalog insulin three times daily and was being administered the insulin on a sliding scale based on his BS reading which left the resident at times without any Humalog being administered. On 03/13/25, the resident was supposed to be administered 8 units of Humalog but was administered 15 units; his BS reading dropped to 42, and the resident was taken to see his PCP (#2), and a resident who had a diagnosis of COPD, and was not administered his breathing treatment medication as ordered which put the resident at risk of shortness of breath and wheezing (#1). This failure put the residents at substantial risk for harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/12/25. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 12, 2025.	D 358		